

Doctor's Order Sheet
**CARBOplatin AUC 5 -
 Caelyx® (liposomal
 DOXOrubicin) 30 - Zirabev®
 (bevacizumab) 10 mg/kg
 Regimen (Part I)**

ARIA Protocol Name: CarbAUC5 Caelyx30 Zirabev (bevacizumab)10
 Adult Chemotherapy - Gynecologic Oncology
 Epithelial Ovarian, Primary Peritoneal or
 Fallopian Tube Carcinoma Therapy



CC3160 0426 11 2023

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY
 Cycle _____ of _____

Planned Administration Date: DD/MONTH/YYYY
Cycle Duration: 28 days Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10⁹/L and platelets **greater than or equal to** 100 X 10⁹/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Dipstick urine or laboratory urinalysis for protein assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

ondansetron 8 mg PO on day 1

dexamethasone 8 mg PO on day 1

Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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Doctor's Order Sheet
**CARBOplatin AUC 5 -
 Caelyx® (liposomal
 DOXOrubicin) 30 - Zirabev®
 (bevacizumab) 10 mg/kg**

Regimen (Part II)
ARIA Protocol Name: CarbAUC5 Caelyx30 Zirabev (bevacizumab)10
 Adult Chemotherapy - Gynecologic Oncology
 Epithelial Ovarian, Primary Peritoneal,
 or Fallopian Tube Carcinoma Therapy



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Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- Caelyx® (liposomal DOXOrubicin) 30 mg/m² X BSA = _____ mg**
 Dose modification: **Caelyx® (liposomal DOXOrubicin) 30 mg/m² X BSA - _____ % = _____ mg**
IV in 250 mL D5W over 60 minutes on day 1

To minimize the risk of infusion reactions, the initial dose is administered at a rate no greater than 1 mg/minute. If no infusion reaction is observed, subsequent infusions may be administered over 60 minutes.

- CARBOplatin AUC 5 = _____ mg**
 Dose modification: **CARBOplatin AUC 5 - _____ % = _____ mg**
IV in 250 mL normal saline over 30 minutes on day 1

- Zirabev® (bevacizumab) 10 mg/kg X weight (kg) = _____ mg**
IV in 100 to 250 mL normal saline on days 1 and 15 over:
 — **60** minutes for the first infusion;
 — If tolerated without reaction - **20** minutes for all subsequent infusions

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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