CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

trifluridine/tipiracil 35 - Mvasi® (bevacizumab) 5 mg/kg Regimen

ARIA Protocol Name: Trifluridine/Tipiracil 35 Mvasi (bevacizumab) 5
Adult Chemotherapy - Medical Oncology
Unresectable Colorectal Carcinoma

Name:
HCN:
Date of Birth
BirthBirth:

tal Carcinoma

CC6770 0497 06/2024

Allergies: ☐ **No Known**

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

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Medical Oncologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed.
- Assess dipstick urine or laboratory urinalysis for protein

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ Other: ______________________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Mvasi®** (**bevacizumab) 5 mg/kg** X weight (kg) = _________ **mg**
IV in 100 mL normal saline over 10 minutes on days 1 and 15.

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **trifluridine/tipiracil 35 mg/m²** X BSA = _________**mg**
☐ Dose modification: **trifluridine/tipiracil 35 mg/m²** X BSA - _______% = _________**mg**
PO BID on days 1 to 5 and days 8 to 12. **Round to nearest 5 mg, maximum dose of 80mg.**
This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist.

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: ______________________

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.