CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CAPOX + Bevacizumab Regimen:

Oxaliplatin-Capecitabine -Bevacizumab (Part I)

Adult Chemotherapy- Medical Oncology

Metastatic Colorectal Carcinoma

CC1340 0005 06 2017

Name:

HCN:

Date of Birth:

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.2 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, BP **less than or equal to** 160/100, Creatinine Clearance **greater than** 50 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Dipstick Urine or laboratory urinalysis for protein at the beginning of each odd (1, 3, 5) numbered cycle. If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein, collect 24 hour urine for total protein within 3 days before the next cycle. If this result is abnormal, dose reductions are required

PREMEDICATIONS:

☐ **Ondansetron 8 mg PO**

☐ **Dexamethasone 8 mg PO**

☐ Other: _____

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

Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
CAPOX + Bevacizumab Regimen:
Oxaliplatin-Capecitabine -Bevacizumab (Part II)
Adult Chemotherapy- Medical Oncology
Metastatic Colorectal Carcinoma

CC1340 0005 06 2017

Name:

HCN:

Date of Birth:

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Oxaliplatin 130 mg/m²** X BSA = _____mg IV in 500 mL D5W over 120 minutes on day 1

☐ Dose modification: **130 mg/m²** X BSA - _____% = _____mg IV in 500 mL D5W over 120 minutes on day 1

☐ **Bevacizumab 7.5 mg/kg** X weight (kg) = _____mg IV in 100 mL normal saline over:

- **90** minutes during **Cycle 1**;
- If tolerated without reaction- **60** minutes during **Cycle 2**;
- If tolerated without reaction- **30** minutes during **Cycle 3**;
- If tolerated without reaction-**15** minutes during **Cycle 4** and all other cycles

(Prior to and post administration, flush lines with normal saline as Bevacizumab is not compatible with D5W; blood pressure measurement pre and post dose for first 3 cycles; and prior to Bevacizumab for subsequent cycles)

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **Capecitabine 1000 mg/m²** X BSA = _____mg PO bid with food on days 1 to 14

☐ Dose modification: **1000 mg/m²** X BSA - _____% = _____mg PO bid with food on days 1 to 14

This prescription is NOT eligible for medication management by a pharmacist.

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

Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____