BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: GIATZB

DOCTOR'S ORDERS

Ht___________cm Wt__________kg BSA___________m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)

May proceed with doses as written if within 96 hours **ALT less than or equal to 3 times the upper limit of normal, bilirubin less than or equal to 1.5 times the upper limit of normal, creatinine less than or equal to 1.5 times the upper limit of normal** *and* **less than or equal to 1.5 X baseline, BP less than or equal to 160/100.** For those patients on warfarin, hold bevacizumab if **INR greater than 3.0**

Proceed with treatment based on blood work from ______________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm __________________________.

For prior infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment

☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment

☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY: ☐ Repeat in three weeks

atezolizumab 1200 mg IV in 250 mL NS over 30 minutes (first infusion over 1 hour)

bevacizumab 15 mg/kg x ___________ kg = __________ mg
IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour).
(Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles.)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190 (note: only biosimilars are funded)

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle ______ ☐ Return in **six** weeks for Doctor and Cycles ______ and ______. Book chemo x 2 cycles. ☐ Last cycle. Return in ______ **week(s)**	
CBC and differential, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium TSH, Blood Pressure Measurement prior to each treatment ☐ **Dipstick Urine or** ☐ **laboratory urinalysis** (select one) **for protein** at the beginning of each even numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then a 24 hr urine for total protein must be done within 3 days prior to next cycle.) If clinically indicated: ☐ **AFP** ☐ **ECG** ☐ **Chest X-ray *or*** ☐ **CT Chest** ☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **Glucose** ☐ **Calcium** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential ☐ **Weekly nursing assessment** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**