METRO INFUSION CENTER

Name: ___________________________________________

DOB: ____________________________________________

Diagnosis/Code: ______________ /_______________

Cancer Stage: ________________________________

**Bevacizumab**

**___Avastin ___Mvasi ___ zirabev ___Alymsys ___vegzelma**

**Weight: ______ lb _____ kg**

Call for weight change greater than 10% from weight listed on order

No dose modifications required for any weight change

**BSA:** N/A

Mg/Kg dosing

**Patient Clearance:** **Attach treatment Consent Form ☐**

Patient will be seen by Oncology Provider prior to every ___ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/___________days

**Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:**

**Will be done at referring office** (Name and phone# of who to expect labs from):

☐ CMP with each treatment ☐ CBC with each treatment

☐ Other: Urine protein every ___ treatment

**Dosing Guidelines/Parameters:** ***Provider must select parameters that will trigger a call from the Infusion staff***

☐ Hold and call provider for ANC: ___________________ /Platelet:_________________________________

☐ Other hold parameters +___urine protein

☐ No hold parameters

**Hydration Orders:**

Not required

**Premedication and Antiemetic orders:** Not required (low emetogenic potential)

**Treatment orders:**

| DRUG | DOSE CALCULATION Flat dosing | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES |
|---|---|---|---|---|---|---|
| ☐ Bevacizumab | 5mg/kg | ________mg | As Per Pharmacy | IVPB | ___ over 90 minutes (1st dose)<br>___ over 60 minutes (2nd dose)<br>___over 30 minutes (3rd dose +) | ___every 2 weeks<br>___every 3 weeks |
| ☐ Bevacizumab | 7.5mg/kg | _____mg | As Per Pharmacy | IVPB | ___ over 90 minutes (1st dose)<br>___ over 60 minutes (2nd dose)<br>___over 30 minutes (3rd dose +) | ___every 2 weeks<br>___every 3 weeks |
| ☐ Bevacizumab | 10mg/kg | ____mg | As Per Pharmacy | IVPB | ___ over 90 minutes (1st dose)<br>___ over 60 minutes (2nd dose)<br>___over 30 minutes (3rd dose +) | ___every 2 weeks<br>___every 3 weeks |
| ☐ Bevacizumab | 15mg/kg | ____mg | As Per Pharmacy | IVPB | ___ over 90 minutes (1st dose)<br>___ over 60 minutes (2nd dose)<br>___over 30 minutes (3rd dose +) | ___every 2 weeks<br>___every 3 weeks |
| | | | | | | |

Date of intended first treatment at Metro Infusion Center:

Subsequent treatment may be given +/- 2 days or as otherwise specified:

***This order is good for 1 year from the date ordered***

**Other:**

Oral cancer treatment patient is taking:

**Call referring provider for:**

1. Blood pressure_____________(Provider to insert BP to be called for ( ); MIDC/MIC staff to assure this is not one time reading.
2. Nose bleeds
3. + 2 protein on urinalysis
4. Persistent headaches unresolved by medication
5. Any recent surgery/Invasive procedures within the last 4 weeks.

Other reasons to call:

Date: Referring Provider: _____________________ _____________________ Phone# ____________

**SIGNATURE REQUIRED** **PRINTED NAME REQUIRED**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164.