MIC | 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) ☐ over 60 minutes (2nd dose) ☐ over 30 minutes (3rd dose +)	☐ every 2 weeks ☐ every 3 weeks
☐ Bevacizumab	7.5mg/kg	_____mg	As Per Pharmacy	IVPB	☐ over 90 minutes (1st dose) ☐ over 60 minutes (2nd dose) ☐ over 30 minutes (3rd dose +)	☐ every 2 weeks ☐ every 3 weeks
☐ Bevacizumab	10mg/kg	_____mg	As Per Pharmacy	IVPB	☐ over 90 minutes (1st dose) ☐ over 60 minutes (2nd dose) ☐ over 30 minutes (3rd dose +)	☐ every 2 weeks ☐ every 3 weeks
☐ Bevacizumab	15mg/kg	_____mg	As Per Pharmacy	IVPB	☐ over 90 minutes (1st dose) ☐ over 60 minutes (2nd dose) ☐ over 30 minutes (3rd dose +)	☐ every 2 weeks ☐ 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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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