MIC METRO INFUSION CENTER

Bevacizumab (Avastin)-Biosimilars that can be used: ☐ Mvasi (bevacizumab-awwb) ☐ Zirabev (bevacizumab-bvzr)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Weight: _____kg

☐ Call for weight change greater than 10 % from baseline
☐ No dose modifications required for any weight change

BSA N/A:
Mg/Kg dosing

Laboratory or Other Tests Related to Chemotherapy:
CBC/differential prior to ☐ each cycle; ☐ CBC with Differential every _____cycle
☐ Urine protein every _____ cycles (call if a urine protein has not been done in 3 cycles)

Dosing Guidelines/ Parameters:
☐ Hold and all provider for ANC less than 1000 and Platelets less than 75,000
☐ Hold and call provider for ANC less than_____; Platelet less than _____
☐ Urine protein +2
☐ No hold parameters

Hydration Orders: Not Required

Premedication and Antiemetic Orders: ☐ Not Required (minimal emetogenic potential)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN, AND TOTAL DOSES
☐ Bevacizumab (CNS Tumors)	5mg/kg	_____mg	100ml NS	IVPB	☐ 30 min ☐ 10 min	☐ Every 2 weeks ☐ Every 3 weeks
☐ Bevacizumab ***(circle indication)*** (CNS tumors/ GI tumor with oral xeloda)	7.5mg/kg	_____mg	100ml NS	IVPB	☐ 30 min ☐ 15 min	Every 3 weeks
☐ Bevacizumab ***(circle indication)*** (CNS Tumors/Kidney Ca)	10mg/kg	_____ mg	100 ml NS	IVPB	☐ 90 min 1st dose ☐ 60 min 2nd dose ☐ 30 min all other	Every 2 weeks
☐ Bevacizumab ***(circle indication)*** (angiosarcoma/ CNS tumors/ Cervical Ca/Kidney Ca/ Ovary Ca/ Sex cord/ endometrial/ Lung)	15mg/kg	_____mg	100ml NS	IVPB	☐ 90 min 1st dose ☐ 60 min 2nd dose ☐ 30 min all other	Every 3 weeks

Date of first treatment: _____/subsequent treatments may be given +/- 2 days
This order is good for 1 year from the date ordered

Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Blood pressure that is trending up from baseline by 20%
2. Nose bleeds
3. + 2 protein on urinalysis
4. Persistent headaches unresolved by medication

Other reasons to call:

DATE	Referring Provider:_____ _____ Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com