PROTOCOL CODE: BRAVPALAI

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(s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, platelets, creatinine** day of treatment

Cycles 1 to 6, for Day 1 and Day 15 (if ordered): May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

Cycle 7 onwards: May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Other Toxicity**_____

Proceed with treatment based on blood work from_____

TREATMENT:

palbociclib 125 mg or _____ mg PO once daily x 21 days on Days 1 to 21, then 7 days off x ___ cycle(s)

PLUS

☐ **letrozole 2.5 mg** PO daily continuously **Mitte: _____ tablets** **Repeat x _____**

OR

☐ **anastrozole 1 mg** PO daily continuously **Mitte: _____ tablets** **Repeat x _____**

For women needing chemically induced menopause and male patients:

PLUS

goserelin long acting (ZOLADEX) ☐ **3.6 mg** subcutaneous every 4 weeks x _____treatments

goserelin long acting (ZOLADEX LA) ☐ **10.8 mg** subcutaneous every 12 weeks x _____treatments

OR

leuprolide long acting (LUPRON DEPOT) ☐ **7.5 mg** IM every 4 weeks x _____treatments

☐ **22.5 mg** IM every 12 weeks x _____treatments

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

Cycles 7 onwards:

☐ Return in _____ weeks for Doctor and Cycle _____

☐ Last Cycle. RTC in _____ week(s).

Cycles 1 to 6: CBC & Diff, Platelets, creatinine prior to each cycle.

Cycle 1: CBC & diff, platelets on Day 15

☐ **Cycle 2:** CBC & diff, platelets on Day 15

Cycles 1 and 2: CBC & diff, platelets on Day 22 if ANC on Day 15 is 0.5 to less than 1.0

Cycles 7 onwards: CBC & diff, platelets, creatinine prior to ☐ **each cycle**
☐ **every third cycle**

If Clinically Indicated:

☐ **alkaline phosphatase** ☐ **ALT** ☐ **total bilirubin**
☐ **LDH** ☐ **GGT** ☐ **CA15-3** ☐ **ECG**
☐ **Serum cholesterol** ☐ **Triglycerides**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for further orders**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: