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: UBRAJABEAI



*A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.*

## DOCTOR'S ORDERS

**Ht**_____**cm** **Wt**_____**kg** **BSA**_____**m²**

**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

For Day 1 and Day 15 (if ordered): 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, ALT less than 5 x ULN, and total bilirubin less than 2 x ULN**

Dose modification for: ☐ Other Toxicity_____
Proceed with treatment based on blood work from_____

## TREATMENT:

**abemaciclib 150 mg** PO twice daily

Dose modification if required:

☐ **abemaciclib 100 mg** PO twice daily (dose level -1)
☐ **abemaciclib 50 mg** PO twice daily (dose level -2)

Mitte: _____ days

(28 day supply for first 3 months of therapy; may dispense up to 84 day supply after 3 months)

**PLUS**

☐ **letrozole 2.5 mg** PO daily continuously Mitte: _____ tablets Repeat x _____
**OR**
☐ **anastrozole 1 mg** PO daily continuously Mitte: _____ tablets Repeat x _____
**OR**
☐ **exemestane 25 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:**<br><br>**UC:** |
|---|---|

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**Date:**

## RETURN APPOINTMENT ORDERS

**Cycles 1 to 3:**

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

**Cycles 4 onwards:**

☐ Return in _____ weeks for Doctor and cycle _____

☐ Last Cycle. Return in _____ week(s) for Doctor and _____ to continue endocrine therapy per protocol:

☐ BRAJLET, ☐ BRAJANAS, ☐ BRAJEXE, ☐ BRAJLHRHAI, ☐ BRAJTAM or ☐ BRAJLHRHT (select one)

Cycles 1 and 2:

**CBC & Diff, platelets, total bilirubin, ALT** on Day 15

Cycles 1 to 3:

**CBC & Diff, platelets, creatinine, total bilirubin, ALT, urea** every month

Cycle 4 onwards:

**CBC & Diff, platelets, creatinine, total bilirubin, ALT, urea** ☐ every month or ☐ every 3 months

If clinically indicated: ☐ **sodium** ☐ **potassium** ☐ **calcium** ☐ **albumin** ☐ **magnesium**
☐ **alkaline phosphatase** ☐ **GGT** ☐ **serum cholesterol** ☐ **triglycerides**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for further orders**

| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |
|---|---|