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: UGINETEV

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

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

One cycle = 4 weeks

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _______ week(s)

☐ **CBC & Diff, Platelets** day of treatment

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 75 x 10^9/L**

Proceed with treatment based on blood work from ________________________________

PREMEDICATIONS: Patient to take own supply.

☐ dexamethasone mouthwash (see protocol). Start on Day 1 of everolimus treatment; continue for 8 weeks (2 cycles). May continue up to a maximum of 16 weeks (4 cycles) at the discretion of the treating oncologist.

Treatment:

☐ **everolimus 10 mg** PO daily

☐ **everolimus 5 mg** PO daily (dose level -1)

☐ **everolimus 5 mg** PO every other day (dose level -2)

Mitte: ________ days supply of everolimus (max: 30 days)

RETURN APPOINTMENT ORDERS

☐ Return in ________ weeks for Doctor and Cycle __________

☐ Last Cycle. Return in ________ week(s).

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Glucose prior to each cycle

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos**
☐ **ALT** ☐ **LDH** ☐ **BUN** ☐ **Creatinine**
☐ **Glucose** ☐ **Tot. cholesterol** ☐ **Triglycerides**
☐ **Calcium** ☐ **Phosphate**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: