



Provincial Health Services Authority

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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

### PROTOCOL CODE: UGUPAVOABI

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

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| <b>DOCTOR'S ORDERS</b>   |  |
| <b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>  |  |
| <b>DATE:</b>   | <b>To be given:</b> <span style="float: right;"><b>Cycle #:</b></span> |
| Date of Previous Cycle:  |  |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment  |  |
| May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/L.</b>  |  |
| Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity:</b> _____  |  |
| Proceed with treatment based on blood work from _____  |  |
| <b>TREATMENT:</b>  |  |
| <b>olaparib 300 mg</b> PO twice daily<br>Dose modification:<br><input type="checkbox"/> <b>olaparib 250 mg</b> OR <input type="checkbox"/> <b>olaparib 200 mg</b> OR <input type="checkbox"/> <b>olaparib 150 mg</b> PO twice daily (select one)<br>Mitte: 30 days<br>* Dispense in original container   |  |
| <b>abiraterone 1000 mg</b> PO once daily<br>Dose modification:<br><input type="checkbox"/> <b>abiraterone 750 mg</b> OR <input type="checkbox"/> <b>500 mg</b> OR <input type="checkbox"/> <b>250 mg</b> PO once daily (select one)<br>Mitte: 30 days  |  |
| <b>STEROID (select one of the following steroids and doses)</b>  |  |
| <input type="checkbox"/> <b>predniSONE</b> <input type="checkbox"/> <b>5 mg</b> PO twice daily or <input type="checkbox"/> <b>10 mg</b> PO once daily or <input type="checkbox"/> <b>5 mg</b> PO once daily<br>Mitte: 30 days  |  |
| <input type="checkbox"/> <b>dexamethasone</b> <input type="checkbox"/> <b>1.5 mg</b> PO once daily OR <input type="checkbox"/> <b>0.5 mg</b> PO once daily<br>Mitte: 30 days   |  |
| <b>RETURN APPOINTMENT ORDERS</b>   |  |
| <input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)<br><input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)<br><input type="checkbox"/> Last Cycle. Return in _____ week(s).  |  |
| Prior to each cycle: <b>CBC &amp; Diff, total bilirubin, ALT, alkaline phosphatase, creatinine, random glucose, sodium, potassium, blood pressure, PSA</b><br>Cycles 1 to 3, every 2 weeks: <b>potassium, ALT, total bilirubin, alkaline phosphatase</b><br>If clinically indicated: <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> on Day 14<br>If clinically indicated:<br><input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>MUGA scan</b> or <input type="checkbox"/> <b>echocardiogram</b> <input type="checkbox"/> <b>total protein</b> <input type="checkbox"/> <b>albumin</b><br><input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>urea</b> <input type="checkbox"/> <b>TSH</b> <input type="checkbox"/> <b>calcium</b> <input type="checkbox"/> <b>INR</b> <input type="checkbox"/> <b>testosterone</b><br><input type="checkbox"/> <b>Other tests:</b><br><input type="checkbox"/> <b>Consults:</b><br><input type="checkbox"/> <b>See general orders sheet for additional requests.</b> |  |
| <b>DOCTOR'S SIGNATURE:</b>   | <b>SIGNATURE:</b>  |
|  | <b>UC:</b>   |