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: GOOVNIRAM

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)

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

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Hemoglobin greater than or equal to 80 g/L**.

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

niraparib (select one)

☐ **300 mg** PO once daily
☐ **200 mg** PO once daily
☐ **100 mg** PO once daily

Mitte _____ weeks Repeat x _____

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)

☐ Return in ____ weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)

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

Cycle 1: CBC & Diff, Platelets ☐ weekly x 4 weeks
☐ on day 14

Every four weeks (cycles 2 to 12): CBC & Diff, Platelets, blood pressure measurement prior to each cycle

After cycle 12: CBC & diff, platelets ☐ every four weeks ☐ prior to RTC

If indicated: ☐ CBC & Diff, Platelets on day 14.

If clinically indicated: ☐ Creatinine ☐ ALT ☐ bilirubin ☐ Alk Phos
☐ CA 125 ☐ CA 15-3 ☐ CA 19-9 ☐ CEA

☐ CT C/A/P in _____weeks.
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: