



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: UGUTEM

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

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form
One cycle consists of 4 weeks of once weekly temsirolimus

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

Date of Previous Cycle: _____

Delay treatment _____ week(s)

CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to $1 \times 10^9/L$, Platelets greater than or equal to $75 \times 10^9/L$**

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

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

Diphenhydramine 25 mg or 50 mg (circle one) IV in 50 mL NS over 20 minutes prior to Temsirolimus

Other: _____

**** Have Hypersensitivity Reaction Tray and Protocol Available ****

CHEMOTHERAPY:

Temsirolimus 25 mg

Dose Modification: 20 mg or 15 mg (circle one)

IV in 250 mL NS (non-PVC bag) over 30 minutes weekly x _____ weeks.

(use non-PVC tubing with in-line filter)

RETURN APPOINTMENT ORDERS

Return in _____ week(s) for Doctor and Cycle _____ week _____.

Book weekly treatment x _____ weeks

Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to each treatment

Electrolytes, Creatinine, BUN, Glucose, Calcium, Phosphorus, AST, LDH, Total Bili, Alk. Phos., Total Cholesterol, Triglycerides prior to each cycle (every 4 weeks)

If clinically indicated: Tot. Prot Albumin GGT ALT INR/PTT

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: