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: BRAVEVEX

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 #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** 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's 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

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

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

Mitte: _____days supply of everolimus (Cycle 1: max 30 days, Cycle 2 onwards: max 90 days)

AND

exemestane 25 mg PO daily. Mitte:_____days

RETURN APPOINTMENT ORDERS

☐ Cycle 1: Return in 4 weeks for Doctor and Cycle 2

☐ Cycle 2 onwards : Return in ☐ 4 weeks **OR** ☐ 8 weeks for Doctor and Cycle _____

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

Prior to cycle 2 then prior to each return to clinic (RTC): **CBC & Diff**

If clinically indicated:
☐ **total protein** ☐ **albumin** ☐ **total bilirubin** ☐ **INR** ☐ **GGT** ☐ **ALT**
☐ **alkaline phosphatase** ☐ **LDH** ☐ **urea** ☐ **creatinine** ☐ **random glucose**
☐ **total cholesterol** ☐ **triglycerides** ☐ **sodium** ☐ **potassium** ☐ **calcium**
☐ **HbA1c** ☐ **magnesium**
☐ **phosphate** ☐ **creatine kinase** ☐ **dipstick or laboratory urinalysis for protein**
☐ **24-hour urine protein** within 3 days prior to next cycle if laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: