



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 and according to acceptable standards of care

PROTOCOL CODE: BRAVPALAI

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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

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)
- CBC & Diff, platelets, creatinine day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L.**

Dose modification for: Other Toxicity _____

Proceed with treatment based on blood work from _____

TREATMENT:

palbociclib 125 mg or _____ mg PO once daily x 21 days on Days 1 to 21, then 7 days off x ____ cycle(s)

PLUS

letrozole 2.5 mg PO daily continuously **Mitte:** _____ tablets **Repeat x** _____

OR

anastrozole 1 mg PO daily continuously **Mitte:** _____ tablets **Repeat x** _____

For women needing chemically induced menopause:

PLUS

- buserelin long acting (SUPREFACT DEPOT)
- 6.3 mg subcutaneous every 6 weeks x 2 treatments
 - 6.3 mg subcutaneous every 8 weeks x _____ treatments
 - 9.45 mg subcutaneous every 12 weeks x _____ treatments

OR

- goserelin long acting (ZOLADEX)
- 3.6 mg subcutaneous every 4 weeks x _____ treatments
- goserelin long acting (ZOLADEX LA)
- 10.8 mg subcutaneous every 12 weeks x _____ treatments

OR

- leuprolide long acting (LUPRON DEPOT)
- 7.5 mg IM every 4 weeks x _____ treatments
 - 22.5 mg IM every 12 weeks x _____ treatments

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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| DOCTOR'S ORDERS | |
|--|-------------------|
| DATE: | |
| RETURN APPOINTMENT ORDERS | |
| <input type="checkbox"/> Return in four weeks for Doctor and Cycle _____ Cycles 7 onwards: <input type="checkbox"/> Return in ____ weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. RTC in _____ week(s). | |
| Cycles 1 to 6: CBC & Diff, Platelets, creatinine prior to each cycle. Cycles 1 and 2: CBC & diff, platelets on Day 15 Cycles 7 onwards: CBC & diff, platelets, creatinine prior to <input type="checkbox"/> each cycle <input type="checkbox"/> every third cycle If Clinically Indicated: <input type="checkbox"/> Alk Phos <input type="checkbox"/> ALT <input type="checkbox"/> Bilirubin <input type="checkbox"/> LDH <input type="checkbox"/> GGT <input type="checkbox"/> CA15-3 <input type="checkbox"/> ECG <input type="checkbox"/> Serum cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for further orders | |
| DOCTOR'S SIGNATURE: | SIGNATURE: |
| | UC: |