



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: UBRAVCAFLV

(Page 1 of 2)

A BC Cancer "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

DATE: _____ **To be given:** _____ **Cycle(s) #:** _____

Date of Previous Cycle: _____

- ☐ Delay treatment _____ week(s)
☐ **fasting glucose** day of treatment

May proceed with doses as written if within 96 hours **fasting glucose less than or equal to 8.9 g/L.**

Dose modification for: ☐ **fasting glucose** ☐ **diarrhea** ☐ **cutaneous adverse reactions** ☐ **other toxicity** _____

Proceed with treatment based on blood work from _____

TREATMENT:

- ☐ **capivasertib** 400 mg PO twice daily x 4 consecutive days, followed by 3 days off. Repeat weekly.

Dose modification if required:

- ☐ **capivasertib** 320 mg PO twice daily x 4 consecutive days, followed by 3 days off. Repeat weekly.
☐ **capivasertib** 200 mg PO twice daily x 4 consecutive days, followed by 3 days off. Repeat weekly.

Mitte: 28 days supply

PLUS

Cycle 1:

- ☐ **fulvestrant** 500 mg IM on days 1 and 15.
Administer as two 250 mg injections.

Cycle 2 onwards:

- ☐ **fulvestrant** 500 mg IM every 28 days. Mitte: _____ injections Repeat x _____
Administer as two 250 mg injections.

For women needing chemically induced menopause and male patients:

PLUS

- 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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(Page 2 of 2)

DOCTOR'S ORDERS	
DATE:	
RETURN APPOINTMENT ORDERS	
<p>Cycle 1:</p> <p><input type="checkbox"/> Book fulvestrant injections on Days 1 and 15.</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle 2.</p> <p>Cycle 2 onwards:</p> <p><input type="checkbox"/> Book fulvestrant injections every 28 days x _____ injections.</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Return in _____ weeks for Doctor and Cycle(s) _____</p> <p><input type="checkbox"/> Last Cycle. RTC in _____ week(s).</p>	
<p>CBC & Diff, fasting glucose prior to each cycle.</p> <p>Cycles 1 and 2: fasting glucose weekly</p> <p>If clinically indicated:</p> <p><input type="checkbox"/> HbA1C prior to cycle 2</p> <p>HbA1C every 12 weeks (prior to cycles 4, 7, 10, 13, 16, etc)</p> <p>If clinically indicated, prior to next cycle:</p> <p><input type="checkbox"/> ECG</p> <p><input type="checkbox"/> HbA1C <input type="checkbox"/> fasting glucose weekly <input type="checkbox"/> creatinine <input type="checkbox"/> sodium <input type="checkbox"/> potassium</p> <p><input type="checkbox"/> calcium <input type="checkbox"/> magnesium <input type="checkbox"/> lactate <input type="checkbox"/> serum ketones <input type="checkbox"/> albumin <input type="checkbox"/> ALT</p> <p><input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> total bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> LDH <input type="checkbox"/> CA15-3</p> <p><input type="checkbox"/> triglycerides</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults: <input type="checkbox"/> endocrinology <input type="checkbox"/> dermatology <input type="checkbox"/> other _____</p> <p><input type="checkbox"/> See general orders sheet for further orders</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: