PROTOCOL CODE: UBRAVPALAI

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

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)

☐ **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 10^9/L, Platelets greater than or equal to 50 x 10^9/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:

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

Cycles 7 onwards:

☐ Return in ____ weeks for Doctor and Cycle _____

☐ 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 ☐ **each cycle**
☐ **every third cycle**

If Clinically Indicated: ☐ **Alk Phos** ☐ **ALT** ☐ **Bilirubin** ☐ **LDH** ☐ **GGT**
☐ **CA15-3** ☐ **ECG** ☐ **Serum cholesterol**
☐ **Triglycerides**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for further orders**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: