



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: UBRAVRIBAI

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BC Cancer "Compassionate Access Program" approval must be obtained prior to treatment

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 75 x 10⁹/L.**

Dose modification for: Other Toxicity _____

Proceed with treatment based on blood work from _____

TREATMENT:

ribociclib 600 mg or _____ mg (select one) PO once daily in the morning 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	
<p>Cycles 1 to 6:</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle _____</p> <p>Cycles 7 onwards:</p> <p><input type="checkbox"/> Return in ____ weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Last Cycle. RTC in _____ week(s).</p>	
<p>Cycle 1 (Days 1 and 15): CBC & diff, platelets, creatinine, albumin, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, calcium, magnesium, phosphorus, ECG</p> <p>Cycle 2: CBC & diff, platelets, creatinine, albumin, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, calcium, magnesium, phosphorus, ECG</p> <p>Cycles 3 to 6: CBC & diff, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin prior to each cycle.</p> <p>Cycles 7 onwards: CBC & diff, platelets, creatinine prior to <input type="checkbox"/> each cycle <input type="checkbox"/> every third cycle</p> <p>If clinically indicated: <input type="checkbox"/>Albumin <input type="checkbox"/>ALT <input type="checkbox"/>Alkaline phosphatase <input type="checkbox"/>Total Bilirubin <input type="checkbox"/>GGT <input type="checkbox"/>LDH <input type="checkbox"/>Sodium <input type="checkbox"/>Potassium <input type="checkbox"/>Calcium <input type="checkbox"/>Magnesium <input type="checkbox"/>Phosphorus <input type="checkbox"/>Serum cholesterol <input type="checkbox"/>Triglycerides <input type="checkbox"/>ECG <input type="checkbox"/>CA15-3 <input type="checkbox"/>CEA <input type="checkbox"/>CA125</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for further orders</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: