PROTOCOL CODE: GIPNEVER

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 to take 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
☐ **everolimus 5 mg** PO daily (dose level -1)
☐ **everolimus 5 mg** PO every other day (dose level -2)

Mitte: 30 days

RETURN APPOINTMENT ORDERS

☐ Return in **4 weeks** for Doctor and Cycle _____

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

CBC & Diff prior to each cycle

If clinically indicated:

☐ **total protein** ☐ **albumin** ☐ **total bilirubin** ☐ **INR** ☐ **GGT**
☐ **alkaline phosphatase** ☐ **LDH** ☐ **ALT** ☐ **urea** ☐ **creatinine**
☐ **random glucose** ☐ **HbA1c** ☐ **total cholesterol** ☐ **triglycerides**
☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **calcium**
☐ **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:

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