PROTOCOL CODE: GUOTEVER

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**

Dose modification for: ☐ Hematology ☐ Other Toxicity: _____

Proceed with treatment based on blood work from _____

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: _____ days (Cycles 1 to 3: maximum 30 days, Cycle 4 onwards: maximum 90 days)

RETURN APPOINTMENT ORDERS

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

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

☐ Return in _____ weeks for Doctor and Cycle _____

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

Prior to Cycles 2 to 4: CBC & Diff, creatinine, urine dipstick or laboratory urinalysis for protein

Cycle 4 onwards, prior to each visit: CBC & Diff, creatinine, urine dipstick or laboratory urinalysis for protein

If clinically indicated:

☐ **total protein** ☐ **albumin** ☐ **total bilirubin** ☐ **INR** ☐ **GGT**

☐ **alkaline phosphatase** ☐ **LDH** ☐ **ALT** ☐ **urea**

☐ **random glucose** ☐ **HbA1c** ☐ **total cholesterol** ☐ **triglycerides** ☐ **sodium**

☐ **potassium** ☐ **magnesium** ☐ **calcium** ☐ **phosphate** ☐ **creatine kinase**

☐ **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:

UC: