



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: UGOOVFOLAM

A BC Cancer "Compassionate Access Program" request form must be completed and approved 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)
On day of treatment: CBC & Diff, Platelets

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L.**

Dose modification for: Hematology Other Toxicity: _____
Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

olaparib (tablets) 300 mg PO twice daily (100% dose). Supply 30 days. Repeat x _____ (after lab work)

Dose modification:

olaparib (tablets) 250 mg PO twice daily. Supply 30 days. Repeat x _____ (after lab work)

olaparib (tablets) 200 mg PO twice daily. Supply 30 days. Repeat x _____ (after lab work)

olaparib (tablets) 150 mg PO twice daily. Supply 30 days. Repeat x _____ (after lab work)

* Dispense in original container

RETURN APPOINTMENT ORDERS

- Return in **four** weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)
- Return in _____ weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)
- Last Cycle. Return in _____ week(s).

Every four weeks: CBC & Diff, Platelets prior to each refill and prior to RTC.

If indicated: CBC & Diff, Platelets on day 14.

- If clinically indicated:
- Creatinine
 - Sodium
 - Potassium
 - ALT
 - Total bilirubin
 - Alk Phos
 - CA 125
 - CA 15-3
 - CA 19-9
 - CEA
 - Tot. Prot
 - Albumin
 - GGT
 - LDH
 - BUN

- CT C/A/P in _____ weeks.
- Other tests:
- Consults:
- See general orders sheet for additional requests.

DOCTOR'S SIGNATURE: _____

SIGNATURE: _____

UC: _____