**PROTOCOL CODE:** UGOOVOLAPM  
A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht ___ cm</th>
<th>Wt ___ kg</th>
<th>BSA ___ m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle(s) #:</th>
</tr>
</thead>
</table>

**DOCTOR’S ORDERS**

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 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 28 days. Repeat x ______ (after lab work)

Dose modification:

- □ olaparib (tablets) 250 mg PO twice daily. Supply 28 days. Repeat x ______ (after lab work)
- □ olaparib (tablets) 200 mg PO twice daily. Supply 28 days. Repeat x ______ (after lab work)
- □ olaparib (tablets) 150 mg PO twice daily. Supply 28 days. Repeat x ______ (after lab work)

**RETURN APPOINTMENT ORDERS**

- □ Return in four weeks for Doctor and Cycle _________ (1 cycle = 28 days)
- □ Return in ____ weeks for Doctor and Cycle _________ (1 cycle = 28 days)

□ Last Cycle. Return in ______ week(s).

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

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:**