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

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: ____________________________

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.