**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  Wt______kg  BSA______m²</th>
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**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)

* Available in 30 day supply containers only: 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 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: