A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
</tr>
</thead>
</table>

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

#### DATE:

<table>
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<tr>
<th>Date of Previous Cycle:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
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</table>

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets
  
  May proceed with doses as written if within 7 days of ruxolitinib initiation and of dispensing the next cycle for first 6 months of therapy; thereafter, within 14 days of dispensing the next cycle.
  
  - ANC greater than or equal to $1 \times 10^9$ /L, Platelets as per protocol

Dose modification for:

- [ ] Hematology
- [ ] Other Toxicity __________________________

#### TREATMENT:

- ruxolitinib [ ] 5 mg, [ ] 10 mg, [ ] 15 mg, [ ] 20 mg or [ ] 25 mg (select one) PO twice daily.

  - Mitte: ______ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)

  Refill x ______

#### RETURN APPOINTMENT ORDERS

- [ ] Return in ______ weeks for Doctor.

During dosage titration: (first six months of treatment)

- [ ] CBC & Diff, Platelets every _____ week(s)

During maintenance:

- [ ] CBC & Diff, Platelets every _____ month(s)

- [ ] Serum Creatinine
- [ ] ALT, Bilirubin

- [ ] Other tests:
- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**