A BCCA “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:**  
Date of Previous Cycle:

- [ ] 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 x 10⁹/L, Platelets as per protocol

Dose modification for:  
- [ ] Hematology  
- [ ] Other Toxicity ____________________________

**CHEMOTHERAPY:**

- ruxolitinib 5 mg, 10 mg, 15 mg, 20 mg or 25 mg (circle 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
- □ AST, ALT, Bilirubin
- □ Other tests:
- □ Consults:
- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**  
**SIGNATURE:**

**UC:**