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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**PROTOCOL CODE: ULKPCVRUX**

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

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<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 #:

**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 1.0 x 10⁹/L, Platelets as per protocol**

**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**

- **ALT, Bilirubin**

- **Other tests:**

- **Consults:**

- **See general orders sheet for additional requests.**

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**