

PROTOCOL CODE: LUNETEV

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form
One cycle = 4 weeks

DATE:

To be given:

Cycle #:

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to $1.0 \times 10^9/L$, Platelets greater than or equal to $75 \times 10^9/L$**

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply.

☐ Dexamethasone mouthwash (see protocol). Start on Day 1 of everolimus treatment; continue for 8 weeks (2 cycles). May continue up to a maximum of 16 weeks (4 cycles) at the discretion of the treating oncologist.

TREATMENT:

☐ **everolimus 10 mg** PO daily

☐ **everolimus 5 mg** PO daily (dose level -1)

☐ **everolimus 5 mg** PO every other day (dose level -2)

Mitte: _____ days (max: 30 days)

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff prior to each cycle

If clinically indicated: ☐ **total protein** ☐ **albumin** ☐ **total bilirubin** ☐ **INR**

☐ **GGT** ☐ **ALT** ☐ **alkaline phosphatase** ☐ **LDH** ☐ **urea** ☐ **creatinine**

☐ **random glucose** ☐ **total cholesterol** ☐ **triglycerides** ☐ **sodium**

☐ **magnesium** ☐ **potassium** ☐ **calcium** ☐ **phosphate** ☐ **creatinine kinase**

☐ **HbA1c** ☐ **dipstick or laboratory urinalysis for protein**

☐ **24-hour urine protein** within 3 days prior to next cycle if laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: