



Provincial Health Services Authority

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 and according to acceptable standards of care

PROTOCOL CODE: BRAVEVEX

(Page 1 of 1)

DOCTOR'S ORDERS	
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form	
DATE:	To be given:
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 75 x 10⁹/L Proceed with treatment based on blood work from _____	
PREMEDICATIONS: Patient's own supply. Dexamethasone mouthwash (see protocol). Start on Day 1 of everolimus treatment; continue for 8 weeks. May continue up to a maximum of 16 weeks at the discretion of the treating oncologist.	
TREATMENT: <input type="checkbox"/> everolimus 10 mg PO daily <input type="checkbox"/> Dose Modification: everolimus 5 mg PO daily (dose level -1) <input type="checkbox"/> Dose Modification: everolimus 5 mg PO every other day (dose level -2) Dispense: _____ days (first dispense: maximum 30 days, subsequent dispenses: maximum 90 days)	
AND exemestane 25 mg PO daily. Dispense: _____ days	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> First 4 weeks of treatment: Return in 4 weeks for Doctor <input type="checkbox"/> First 8 weeks of treatment and onwards: Return in <input type="checkbox"/> 4 weeks OR <input type="checkbox"/> 8 weeks for Doctor	
After first 4 weeks of treatment, then prior to each return to clinic (RTC): CBC & Diff If clinically indicated: <input type="checkbox"/> total protein <input type="checkbox"/> albumin <input type="checkbox"/> total bilirubin <input type="checkbox"/> INR <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> LDH <input type="checkbox"/> urea <input type="checkbox"/> creatinine <input type="checkbox"/> random glucose <input type="checkbox"/> total cholesterol <input type="checkbox"/> triglycerides <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> calcium <input type="checkbox"/> HbA1c <input type="checkbox"/> magnesium <input type="checkbox"/> phosphate <input type="checkbox"/> creatinine kinase <input type="checkbox"/> dipstick or laboratory urinalysis for protein <input type="checkbox"/> 24-hour urine protein within 3 days prior to next RTC if laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+ <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: