BC CANCER
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: GOOVFOLAM

DOCTOR'S ORDERS

Ht______cm Wt_______kg BSA_______m^2

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

DATE: **To be given:** **Cycle(s) #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)
On day of treatment: ☐ **CBC & Diff, Platelets**

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** ______________________
Proceed with treatment based on blood work from ________________________

CHEMOTHERAPY:

☐ **olaparib 300 mg** PO twice daily. Supply 30 days. Repeat x ______ (after lab work)

Dose modification:

☐ **olaparib 250 mg** PO twice daily. Supply 30 days. Repeat x ______ (after lab work)

☐ **olaparib 200 mg** PO twice daily. Supply 30 days. Repeat x ______ (after lab work)

☐ **olaparib 150 mg** PO twice daily. Supply 30 days. Repeat x ______ (after lab work)

* Dispense in original container

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _________ (1 cycle = 4 weeks)
☐ Return in ____ weeks for Doctor and Cycle _________ (1 cycle = 4 weeks)
☐ Last Cycle. Return in ______ week(s).

Every four weeks: CBC & Diff, Platelets prior to each refill and prior to RTC.

If indicated: ☐ **CBC & Diff, Platelets** on day 14.

If clinically indicated: ☐ **Creatinine** ☐ **Sodium** ☐ **Potassium** ☐ **ALT** ☐ **Total bilirubin** ☐ **Alk Phos** ☐ **CA 125** ☐ **CA 15-3** ☐ **CA 19-9** ☐ **CEA** ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **LDH** ☐ **BUN**

☐ CT C/A/P in ________weeks.
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: