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: LKPCVRUX

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 #:**

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 10^9/L, Platelets as per protocol**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

CHEMOTHERAPY:

ruxolitinib ☐ **5 mg,** ☐ **10 mg,** ☐ **15 mg,** ☐ **20 mg or** ☐ **25 mg (select 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: