CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

olaparib 300 mg Regimen

ARIA Protocol Name: olaparib Prostate
Adult Chemotherapy - Medical Oncology
Metastatic Castration-Resistant Prostate Cancer Therapy

Name:
HCN:
Date of Birth:

CC4830 0293 03 2023

Weight: ________kg Height:________________________cm Body Surface Area (BSA) = ____________

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
Cycle______ of ______ **Cycle Duration: 30 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- PSA reviewed (do not hold treatment if results are not available)

PREMEDICATIONS: None recommended

☐ Other: ____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **olaparib 300 mg**

☐ Dose modification: **olaparib 250 mg**

☐ Dose modification: **olaparib 200 mg**

PO BID on days 1 to 30.

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist. Dispense in original container.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: ____________________ Date: DD/MONTH/YYYY Time: _________

Authorized Prescriber's Signature: ____________________ ID #: ____________________

Nurse's Name: ____________________ Date: DD/MONTH/YYYY Time: _________

Nurse's Signature: ____________________

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.