



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**PROTOCOL CODE: ULKCMLD**

- Chronic Phase CML, resistant to Imatinib
- Chronic Phase CML, intolerant to Imatinib
- Accelerated or blast phase CML, resistant to Imatinib
- Accelerated or blast phase CML, intolerant to Imatinib
- Ph + Acute leukemia, resistant to Imatinib
- Ph + Acute leukemia, intolerant to Imatinib

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s)					
<input type="checkbox"/> <b>CBC &amp; Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, BUN. [ECG on treatment initiation.]</b> May proceed with doses as written if within 24 hours of dasatinib initiation, then within 10 days of dispensing the next cycle for first 6 months of therapy; thereafter, within 28 days of dispensing the next cycle.					
<ul style="list-style-type: none"> <li>• For <b>chronic phase: ANC greater than or equal to 1 x 10<sup>9</sup>/L, Platelets greater than or equal to 50 x 10<sup>9</sup>/L. Caution should be exercised for patients with moderate to severe hepatic dysfunction (e.g., bilirubin greater than 2 x ULN, AST and/or ALT greater than 3 x ULN)</b></li> <li>• For <b>accelerated phase or blast crisis or Ph + ALL: Please refer to the ULKCMLD Protocol for hematologic dose modifications. Caution should be exercised for patients with moderate to severe hepatic dysfunction (e.g., bilirubin greater than 2 x ULN, AST and/or ALT greater than 3 x ULN)</b></li> </ul>					
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____					
<b>CHEMOTHERAPY:</b> <input type="checkbox"/> <b>Dasatinib (SPRYCEL®) 80 mg, 100 mg or 140 mg (circle one)</b> PO once daily. ▪ Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months) Refill x _____					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in _____ weeks for Doctor.					
<b>First Month:</b> <input type="checkbox"/> <b>CBC &amp; Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, Uric Acid every _____ week(s)</b> (range: 1-2 weeks)					
<b>Months 2-6:</b> <b>CBC &amp; Diff, Platelets, AST, ALT, Bilirubin every month</b> <input type="checkbox"/> <b>Serum Creatinine, Uric Acid every _____ month(s)</b>					
<b>After 6 months:</b> <b>CBC &amp; Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, Uric Acid</b> <input type="checkbox"/> every month or <input type="checkbox"/> every 3 months					
<input type="checkbox"/> <b>Peripheral blood analysis for quantitative RT-PCR (for BCR/ABL transcripts) every 3 months</b>					
<input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>					
<b>DOCTOR'S SIGNATURE:</b>					<b>SIGNATURE:</b>
					<b>UC:</b>