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: GILEN

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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) for ☐ **Hypertension** ☐ **Diarrhea** ☐ **Other**

☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L**, **platelets greater than or equal to 75 x 10^9/L**, **creatinine clearance greater than or equal to 30 mL/min**, **ALT less than or equal to 5 X ULN**, **total bilirubin less than or equal to 3 X ULN,** and if ordered, **alkaline phosphatase less than or equal to 5 X ULN and urine protein less than 1 g/24 h**

Dose modification for: ☐ **Hematology** ☐ **Hypertension** ☐ **Diarrhea** ☐ **QTc prolongation** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

TREATMENT: One cycle = 30 days **Order in increments of 5 days (only available as 5-day supply unit)**

lenvatinib ☐ **12 mg or** ☐ **8 mg** (select one) **PO** *once* daily. Supply for 30 days.

Or dose modification:

☐ **lenvatinib 4 mg PO** *once* daily. Supply for 30 days.

☐ **lenvatinib 4 mg PO** *once every other day*. Supply for 30 days.

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.
☐ Book Nurse for BP monitoring q 2 weeks x _____.
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, creatinine, total bilirubin, ALT, INR, albumin prior to each cycle

ALT, total bilirubin every two weeks for first 2 months

If clinically indicated:

☐ **AFP** ☐ **ECG** or ☐ **echocardiogram**
☐ **alkaline phosphatase** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **TSH**

☐ **INR** weekly

☐ **Dipstick Urine OR laboratory urinalysis for protein** prior to each cycle
(If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then:

☐ **24 hour urine for total protein** within 3 days prior to next cycle)
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: