PROTOCOL CODE: GISORAF

DOCTOR'S ORDERS

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** 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 50 x 10^9/L**

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

Proceed with treatment based on blood work from _____

TREATMENT: One cycle = 4 weeks

☐ **SORAfenib 400 mg PO** *twice* daily. Supply for 30 days.

☐ **SORAfenib 400 mg PO** *once* daily. Supply for 30 days. (dose level -1)

☐ **SORAfenib 400 mg PO** *once every other day*. Supply for 30 days. (dose level -2)

☐ **SORAfenib 200 mg PO** ☐ **once or** ☐ **twice daily.** *(select one)* Supply for: 30 days.

RETURN APPOINTMENT ORDERS

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

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

If clinically indicated:

☐ **AFP** ☐ **MUGA scan** or ☐ **echocardiogram** ☐ **ECG**
☐ **TSH** ☐ **sodium** ☐ **potassium** ☐ **alkaline phosphatase** ☐ **GGT**
☐ **lipase**
☐ **INR** weekly
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: