PROTOCOL CODE: GISORAF

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form
Continuous treatment, one cycle consists of 4 weeks of SORAfenib

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets** 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 _____

CHEMOTHERAPY: One cycle = 4 weeks

Treatment starting on _____ (date)

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

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

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

☐ **SORAfenib 200 mg PO** ☐ **once or** ☐ **twice daily.** *(select one)* Supply for: _____ 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, Platelets, Creatinine, ALT, Bilirubin prior to each cycle
☐ **Sodium** ☐ **Potassium** ☐ **Magnesium** ☐ **Calcium** ☐ **Phosphate**
☐ **Albumin** ☐ **Lipase** ☐ **Amylase** ☐ **TSH** ☐ **INR**
☐ **AFP**
☐ **MUGA scan or** ☐ **Echocardiography** ☐ **ECG (if clinically indicated)**
☐ **Imaging (appr. every 8 weeks):**

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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