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: UGIAVPANEN

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA _____ m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle (s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

May proceed with doses as written if within 72 hours **ALT less than or equal to 3 X ULN**

Dose modification for: ☐ **Dermatologic toxicity** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____

☐ **Other:**

☐ **magnesium sulfate 2 g** in 50 mL NS over 30 minutes for hypomagnesemia

☐ **magnesium sulfate 5 g** in 100 mL NS over 3 hours for hypomagnesemia

TREATMENT: ☐ **Repeat in two weeks**

PANitumumab 6 mg/kg x _____ kg = _____ mg

☐ Dose Modification: _____ % = _____ mg/kg x _____ kg = _____ mg

IV in 100 mL NS over 1 hour. If tolerated, administer over 30 minutes in subsequent cycles. Use 0.2 micron in-line filter.

encorafenib 300 mg PO daily continuously

Dose modification if required: **encorafenib** ☐ **225 mg** or ☐ **150 mg** (select one) PO daily continuously

Mitte: 15 days (dispense 15-day supply in original container)

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and Cycle _____.
☐ Return in **four** weeks for Doctor and Cycle _____.
☐ Last cycle. Return in _____ week(s).

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

If clinically indicated:

☐ **CEA** ☐ **CA19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **calcium** ☐ **GGT** ☐ **sodium**
☐ **potassium**
☐ **Other tests:**
☐ **Weekly nursing assessment**
☐ **Dermatologic consult** ☐ **Ophthalmology Consult**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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