



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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: UGICABO

Page 1 of 1

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 #:			
Date of Previous Cycle:					
TREATMENT: One cycle = 4 weeks					
<input type="checkbox"/> cabozantinib 60 mg PO daily					
Dose modification:					
<input type="checkbox"/> cabozantinib 40 mg PO daily (dose level -1)					
<input type="checkbox"/> cabozantinib 20 mg PO daily (dose level -2)					
Mitte: 30 days. Repeat x _____ (after lab work)					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____.					
<input type="checkbox"/> Please book Nurse for BP monitoring q 2 weeks x _____.					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff, creatinine, total bilirubin, ALT, INR, albumin prior to each cycle					
If clinically indicated:					
<input type="checkbox"/> AFP <input type="checkbox"/> MUGA scan or <input type="checkbox"/> echocardiogram <input type="checkbox"/> ECG					
<input type="checkbox"/> TSH <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> GGT					
<input type="checkbox"/> urinalysis					
<input type="checkbox"/> INR weekly					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests					
DOCTOR'S SIGNATURE:			SIGNATURE:		
			UC:		