PROTOCOL CODE: UGICABO

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

☐ **cabozantinib 60 mg** PO daily

Dose modification:

☐ **cabozantinib 40 mg** PO daily (dose level -1)

☐ **cabozantinib 20 mg** PO daily (dose level -2)

Mitte: 30 days. Repeat x _____ (after lab work)

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, total bilirubin, ALT, INR, albumin prior to each cycle

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: