DOCTOR’S ORDERS

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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)** for
  - Hypertension
  - Diarrhea
  - Other

- **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 10⁹/L, **Platelets greater than or equal to** 75 x 10⁹/L, **BP less than** 160/100 mmHg, **diarrhea less than or equal to** Grade 2, creatinine clearance **greater than or equal to** 30 mL/min, **alkaline phosphatase, ALT less than or equal to** 5 X ULN, **total bilirubin less than or equal to** 3 X ULN, urine protein less than 1 g/24 h

Dose modification for:
- **Hematology**
- **Hypertension**
- **Diarrhea**
- **Other Toxicity**

Proceed with treatment based on blood work from

TREATMENT: One cycle = 30 days  Order in increments of 5 days (only available as 5-day supply unit)

Treatment starting on ________________ (date)

- lenvatinib 12 mg or 8 mg PO **once** daily. Supply for: _____________ days.
- lenvatinib 4 mg PO **once** daily. Supply for: _____________ days.
- lenvatinib 4 mg PO **once every other day**. 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, Sodium, Potassium, Calcium, Magnesium, ALT, Alkaline phosphatase, Bilirubin, Albumin, TSH, **diystick or laboratory urinalysis for protein**, Blood Pressure Measurement prior to each cycle

Every two weeks for first 2 months: ALT, Alkaline phosphatase, Bilirubin, Albumin, Blood pressure

If clinically indicated:
- **24 hour urine protein within 3 days prior to next cycle** for
- **laboratory urinalysis for protein greater than** 1g/L or **diystick proteinuria 2+ or 3+**
- **total protein**, **GGT**, **LDH**, **BUN**, **ECG**, **INR**, **Echocardiography**
- **AFP**

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

DOCTOR’S SIGNATURE:

SIGNATURE:

UC: