**PROTOCOL CODE: UGISORAF**

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

**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.

<table>
<thead>
<tr>
<th>Date:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Previous Cycle:</td>
<td></td>
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<tr>
<td>□ Delay treatment _____ week(s)</td>
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<tr>
<td>□ CBC &amp; Diff, Platelets day of treatment</td>
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</table>

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:**

**UC:**