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: HNOTLEN

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 #:**

☐ Delay treatment ______ week(s) for: ☐ **Hypertension** ☐ **Diarrhea** ☐ **Other:** _______________

Day of treatment:

☐ **CBC/differential, serum creatinine, alkaline phosphatase, ALT, total bilirubin, albumin, potassium, calcium, magnesium, urine protein, TSH, blood pressure**

☐ **Alkaline phosphatase, ALT, total bilirubin, albumin, blood pressure** ☐ **urine protein** ☐ **TSH**

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 75 x 10^9/L, blood pressure 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, AST or 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** ☐ **QTc prolongation** ☐ **Other Toxicity**

Proceed with treatment based on blood work from ________________________________

TREATMENT:

Consider starting at dose level -1. Order in increments of 5 days (only available as 5-day supply unit)

1 cycle = 30 days

☐ **lenvatinib 24 mg** PO *once* daily. Supply for: ☐ 30 or ☐ 60 days. (select one)

☐ **lenvatinib 20 mg** PO *once* daily. Supply for: ☐ 30 or ☐ 60 days (select one) (dose level -1)

☐ **lenvatinib 14 mg** PO *once* daily. Supply for: ☐ 30 or ☐ 60 days (select one) (dose level -2)

☐ **lenvatinib 10 mg** PO *once* daily. Supply for: ☐ 30 or ☐ 60 days (select one) (dose level -3)

RETURN APPOINTMENT ORDERS

☐ Return in _______ weeks for Doctor and Cycle _______

(Recommend every 2 weeks for the first 2 months)

☐ Last Cycle. Return in _______ week(s).

Prior to each Doctor visit: CBC & Diff, Platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, albumin, potassium, calcium, magnesium, urine protein, TSH, blood pressure

Every two weeks for first 2 months: Blood pressure, Alkaline phosphatase, ALT, total bilirubin, albumin

If clinically indicated: ☐ **Urine Dipstick** ☐ **24 hour urine protein** ☐ **Tot. Prot** ☐ **GGT**

☐ **LDH** ☐ **BUN** ☐ **ECG**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**