PROTOCOL CODE: UHNOTLEN

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

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht_________cm  Wt_________kg  BSA__________m²</th>
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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, potassium, calcium, magnesium, blood pressure, urine protein, TSH
  - Alkaline phosphatase, ALT, total bilirubin, blood pressure [ ] urine protein [ ] TSH

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, 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 ____________________________

CHEMOTHERAPY:
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 once daily with or without food. Supply for: 30 or 60 days. (please circle)
- lenvatinib 20 mg once daily with or without food. Supply for: 30 or 60 days (please circle) (dose level -1)
- lenvatinib 14 mg once daily with or without food. Supply for: 30 or 60 days (please circle) (dose level -2)
- lenvatinib 10 mg once daily with or without food. Supply for: 30 or 60 days (please circle) (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, potassium, calcium, magnesium, urine protein, TSH, blood pressure.

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

If clinically indicated: [ ] Tot. Prot  [ ] Albumin  [ ] GGT  [ ] LDH  [ ] BUN  [ ] ECG

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

DOCTOR’S SIGNATURE:  SIGNATURE:

UC: