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

### 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 #:  

- **Delay treatment** ______ week(s) for:  
  - Hypertension  
  - Diarrhea  
  - Other: ______________

**Day of treatment:**

- CBC/differential, serum creatinine, alkaline phosphatase, AST, ALT, total bilirubin, potassium, calcium, magnesium, blood pressure, urine protein, TSH
- Alkaline phosphatase, AST, 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 x $10^9$/L, Platelets greater than or equal to 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:

Do not break, crush or open capsule. Consider starting at dose level -1. (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** ______ week(s) 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, AST, ALT, total bilirubin, potassium, calcium, magnesium, urine protein, TSH, **blood pressure**

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

Monthly during treatment: Blood pressure, Alkaline phosphatase, AST, ALT, total bilirubin, TSH, urine protein

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:**