**PROTOCOL CODE: LKAMLAS (post-bone marrow transplant)**

**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>
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<tbody>
<tr>
<td>Date of Previous Cycle:</td>
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- [ ] Delay treatment _____ week(s)
- [ ] CBC & Diff, day of treatment

May proceed with doses as written if within **96 hours** ANC **greater than or equal to** 1 x 10⁹/L.

Dose modification for:  

- [ ] Hematology
- [ ] Other Toxicity 

Proceed with treatment based on blood work from ____________________________

**CHEMOTHERAPY:**

Treatment starting on ______________________ (date) (note: start 30 to 100 days post-transplant).

- [ ] SORAfenib 400 mg **twice** daily. Supply for: _____________ days.
- [ ] SORAfenib 400 mg **once** daily. Supply for: _____________ days  (dose level -1)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **four** weeks for Doctor and Cycle ________ (note: maximum of 1 year of treatment =13 cycles).
- [ ] Last Cycle. Return in __________ week(s)

CBC & Diff, Platelets, Creatinine, ALT, Bili prior to each cycle

- [ ] MUGA scan or [ ] Echocardiography (if clinically indicated)

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’s SIGNATURE:**

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