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: LKCMLA

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 #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

May proceed with doses as written if within 7 days of asciminib initiation, then within 10 days of dispensing the next cycle for first 6 months of therapy; thereafter, within 28 days of dispensing the next cycle:

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** _____

CHEMOTHERAPY: Continuous treatment

asciminib ☐ **40 mg** PO twice daily or ☐ **80 mg** PO daily (select one)

Dose modification if required:

asciminib ☐ **20 mg** PO twice daily or ☐ **40 mg** PO daily or (select one)

Mitte: _____ months

(1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

ECG seven days after start of treatment

First month:
CBC & Diff, creatinine, uric acid, sodium, potassium, magnesium, calcium, phosphorous, lipase, blood pressure every 2 weeks

Months 2 and 6:
CBC & Diff, creatinine, uric acid, sodium, potassium, magnesium, calcium, phosphorous, lipase, blood pressure every month

After 6 months:
CBC & Diff, creatinine, uric acid, sodium, potassium, magnesium, calcium, phosphorous, lipase, blood pressure ☐ every month or ☐ every 3 months

☐ **Albumin, triglycerides, cholesterol, creatine kinase, ALT, total bilirubin, alkaline phosphatase every 3 months if clinically indicated**

☐ **HBV viral load**
☐ **Peripheral blood analysis for quantitative RT-PCR (for BCR/ABL transcripts) every 3 months**
☐ **ECG**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: