PROTOCOL CODE: LKCMLD

☐ Chronic Phase CML, resistant to Imatinib
☐ Chronic Phase CML, intolerant to Imatinib
☐ Accelerated or blast phase CML, resistant to Imatinib
☐ Accelerated or blast phase CML, intolerant to Imatinib
☐ Ph + Acute leukemia, resistant to Imatinib
☐ Ph + Acute leukemia, intolerant to Imatinib

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)

☐ **CBC & Diff, Platelets, ALT, Bilirubin, Serum Creatinine, BUN. [ECG** on treatment initiation.]
May proceed with doses as written if within 7 days of dasatinib 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.

- For **chronic phase: ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L.** *Caution should be exercised for patients with moderate to severe hepatic dysfunction* (e.g., **bilirubin greater than 2 x ULN, ALT or AST greater than 3 x ULN**)
- For **accelerated phase or blast crisis or Ph + ALL:** Please refer to the **LKCMLD Protocol for hematologic** dose modifications. *Caution should be exercised for patients with moderate to severe hepatic dysfunction* (e.g., **bilirubin greater than 2 x ULN, ALT or AST greater than 3 x ULN**)

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

CHEMOTHERAPY:

☐ **daSATinib 80 mg, 100 mg or 140 mg (circle one)** PO once daily.
- Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)

Refill x _____

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

First Month:
☐ **CBC & Diff ALT, total bilirubin, creatinine, uric acid every __ week(s)** (range: 1-2 weeks)

Months 2-6:
CBC & Diff, ALT, total bilirubin every month
☐ **creatinine, uric acid every _____ month(s)**

After 6 months:
CBC & Diff, ALT, total bilirubin, creatinine, uric acid ☐ **every month or** ☐ **every 3 months**
☐ **HBV viral load**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: