PROTOCOL CODE: LKCMLI

| DOCTOR'S ORDERS | Ht________ cm  Wt________ kg  BSA________ m² |
|-----------------|-----------------|-----------------|

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

Date of Previous Cycle:

- Delay treatment ______ week(s)
- CBC & Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, BUN

  May proceed with doses as written if within 7 days of iMAtinib 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 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L, bilirubin less than or equal to 3 x ULN, AST and/or ALT less than or equal to 5 x ULN**

  For accelerated phase or blast crisis: **ANC greater than or equal to 0.5 x 10⁹/L, Platelets greater than or equal to 10 x 10⁹/L, bilirubin less than or equal to 3 x ULN, AST and/or ALT less than or equal to 5 x ULN**

Dose modification for:

- Hematology
- Other Toxicity

<table>
<thead>
<tr>
<th>CHEMOTHERAPY:</th>
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<tr>
<td>iMAtinib 400 mg or 600 mg or 300 mg (circle one) PO daily.</td>
</tr>
<tr>
<td>Mitte: ________ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)</td>
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<tr>
<td>OR</td>
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<tr>
<td>iMAtinib 400 mg PO BID</td>
</tr>
<tr>
<td>Mitte: ________ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)</td>
</tr>
</tbody>
</table>

**RETURN APPOINTMENT ORDERS**

- Return in _______ weeks for Doctor.

**First Month:**

- CBC & Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, Uric Acid every __ week(s) (range: 1-2 weeks)

**Months 2-6:**

- CBC & Diff, Platelets, AST, ALT, Bilirubin every month
- Serum Creatinine, Uric Acid every ________ month(s)

**After 6 months:**

- CBC & Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, Uric Acid every month or __ every 3 months
- 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:**