BC Cancer Agency
CARE & RESEARCH

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

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: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, AST, ALT, total bilirubin, creatinine, urea**
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 10^9/L, Platelets greater than or equal to 50 x 10^9/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 10^9/L, Platelets greater than or equal to 10 x 10^9/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** _____

CHEMOTHERAPY:

☐ **iMAtinib** ☐ **400 mg or** ☐ **600 mg or** ☐ **300 mg (select one)** PO daily.
- Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)

OR

☐ **iMAtinib 400 mg** PO BID
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.

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
☐ **creatinine, uric acid** every _____ month(s)

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

☐ **Peripheral blood analysis for quantitative RT-PCR** (for BCR/ABL transcripts) every 3 months

☐ **HBV viral load, if clinically indicated every 3 months**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: