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: LKCMLN

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, ALT, total bilirubin, creatinine, urea, lipase and random glucose.** [**ECG** on treatment initiation.]
May proceed with doses as written if within 7 days of niLOtinib 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.** *Caution should be exercised for patients with moderate to severe hepatic dysfunction* (e.g., **bilirubin greater than** 3 **x ULN, AST and/or ALT greater than** 5 **x ULN – see dosage adjustments in protocol**)

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

CHEMOTHERAPY:

☐ **niLOtinib 400 mg twice daily**

- Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)
  Refill x _____

Dosage adjustment if needed: (Hematological and non-hematological)

☐ **niLOtinib** 400 mg once daily

- Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)
  Refill x _____

☐ Return in _____ weeks for Doctor.

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

Months 2-6:
CBC & Diff, ALT, total bilirubin, lipase, random glucose every month
☐ **Serum Creatinine, Uric Acid every _____ month(s)**

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

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: