PROTOCOL CODE: LKMFRUX

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**

May proceed with doses as written if within 7 days of ruxolitinib initiation and of dispensing the next cycle for first 6 months of therapy; thereafter, within 14 days of dispensing the next cycle.

- **ANC greater than or equal to 1 x 10^9/L, Platelets as per protocol**

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

TREATMENT:

ruxolitinib ☐ **5 mg,** ☐ **10 mg,** ☐ **15 mg,** ☐ **20 mg or** ☐ **25 mg (select one)** PO twice 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.

During dosage titration: (first six months of treatment)

☐ **CBC & Diff** every _____ week(s)

During maintenance:

☐ **CBC & Diff** every _____ month(s)

If clinically indicated:

☐ **creatinine**
☐ **ALT**
☐ **total bilirubin**
☐ **HBV viral load**
☐ **Other tests:**
☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: