**PROTOCOL CODE: ULKAMLAS (post-bone marrow transplant)**

A BCCA “Compassionate Access Program” request form must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

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

Continuous treatment, one cycle consists of 4 weeks of **SORAfenib**

<table>
<thead>
<tr>
<th>Date:</th>
<th>To be given:</th>
<th>Cycle #:</th>
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**Date of Previous Cycle:**

- □ Delay treatment ______ week(s)
- □ CBC & Diff, day of treatment

May proceed with doses as written if within **96 hours ANC greater than or equal to** 1 x 10^9/L

Dose modification for:
- □ Hematology
- □ Other Toxicity

Proceed with treatment based on blood work from _______________

**CHEMOTHERAPY:**

Treatment starting on ________________ (date) (note: start 30 to 100 days post-transplant)

- □ SORAfenib 400 mg **twice** daily. Supply for: _____________ days.
- □ SORAfenib 400 mg **once** daily. Supply for: _____________ days (dose level -1)

**RETURN APPOINTMENT ORDERS**

- □ Return in **four** weeks for Doctor and Cycle ________ (note: maximum of 1 year of treatment =13 cycles).
- □ Last Cycle. Return in _____________ week(s)

CBC & Diff, Platelets, Creatinine, ALT, Bili prior to each cycle

- □ MUGA scan or □ Echocardiography (if clinically indicated)

- □ Other tests:

- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**