PROTOCOL CODE: ULKCMLN

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

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, Platelets, ALT, Bilirubin, Serum Creatinine, BUN, 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, Platelets, ALT, Bilirubin, Serum Creatinine, Uric Acid, Lipase, random glucose every __ week(s)** (range: 1-2 weeks)

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

After 6 months:
CBC & Diff, Platelets, ALT, Bilirubin, Serum 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**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: