

PROTOCOL CODE: LUVALE

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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(s) #:		
Date of Previous Cycle: _____				
TREATMENT:				
alectinib 600 mg PO twice daily				
Dose modification if required:				
<input type="checkbox"/> alectinib 450 mg PO twice daily				
<input type="checkbox"/> alectinib 300 mg PO twice daily				
Supply for: _____ days Repeat x _____				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor				
Cycle 1: Alkaline phosphatase, ALT, total bilirubin, LDH and CPK 2 weeks after starting treatment and prior to next cycle				
Cycle 2 & 3: Alkaline phosphatase, ALT, total bilirubin, and LDH every 2 weeks and prior to next cycle				
Cycle 4 onwards: Alkaline phosphatase, ALT, total bilirubin, and LDH prior to next doctor's visit				
Imaging (approx. every 4-8 weeks): <input type="checkbox"/> Chest X-ray or <input type="checkbox"/> CT Scan (chest)				
If clinically indicated:				
<input type="checkbox"/> ECG <input type="checkbox"/> CPK <input type="checkbox"/> calcium <input type="checkbox"/> potassium <input type="checkbox"/> creatinine				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: