**PROTOCOL CODE: LUAVCRIZF**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht___________cm</th>
<th>Wt___________kg</th>
<th>BSA___________m²</th>
</tr>
</thead>
</table>

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

**DATE:** [Date]

**To be given:** [To be given]

**Cycle #:** [Cycle #]

**Date of Previous Cycle:** [Date of Previous Cycle]

**TREATMENT:**

- [ ] crizotinib 250 mg twice daily. Supply for: _____________ days.

- [ ] crizotinib 200 mg twice daily. Supply for: _____________ days (dose level -1)

- [ ] crizotinib 250 mg once daily. Supply for: _____________ days (dose level -2)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in ______ weeks for Doctor

**CBC, Alk Phos, ALT, Bili, LDH two weeks after starting treatment**

**CBC, Alk Phos, ALT, Bili, LDH at each doctor’s visit**

**Imaging (approx. every 4-8 weeks):**

- [ ] Chest X-ray
- [ ] CT Scan (chest)

- [ ] ECG (if clinically indicated)

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**