**PROTOCOL CODE: LUAVCRIZ**

<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:** To be given: 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

<table>
<thead>
<tr>
<th>CBC &amp; Diff, Platelets, Alk Phos, ALT, Bili, LDH</th>
<th>two weeks after starting treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC &amp; Diff, Platelets, Alk Phos, ALT, Bili, LDH</td>
<td>at each doctor’s visit</td>
</tr>
</tbody>
</table>

Imaging (approx. every 4-8 weeks):
- ☐ Chest X-ray or ☐ CT Scan (chest)
- ☐ ECG (if clinically indicated)

- ☐ Other tests:

- ☐ Consults:

- ☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**