**PROTOCOL CODE: ULUAVCER**

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

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht________cm  Wt________kg  BSA________m^2</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

Date of Previous Cycle:

**TREATMENT:**

- *ceritinib 750 mg* PO once daily on an empty stomach

  Dose modification if required:
  - [ ] *ceritinib 600 mg* PO once daily on an empty stomach (dose level -1)
  - [ ] *ceritinib 450 mg* PO once daily on an empty stomach (dose level -2)

Supply for: __________ days. Repeat x ______

**RETURN APPOINTMENT ORDERS**

- [ ] Return in ______ weeks for Doctor

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

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

Imaging (approx. every 4-8 weeks): [ ] Chest X-ray or [ ] CT Scan (chest)

If clinically indicated:

- [ ] ECG  
- [ ] creatinine  
- [ ] lipase  
- [ ] amylase  
- [ ] fasting glucose  
- [ ] sodium  
- [ ] potassium

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**

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Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care.