PROTOCOL CODE: LYCDA

<table>
<thead>
<tr>
<th>DOCTOR'S ORDERS</th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: To be given: Cycle #:

Date of Previous Cycle:

First cycle: Proceed with full dose as ordered, regardless of blood counts. Adjust dose for Creatinine Clearance only, if required.

If a subsequent cycle is given: May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Creatinine Clearance greater than or equal to 70 mL/min.

Dose modification for: □ Creatinine Clearance □ Other Toxicity _______________________

Proceed with treatment based on blood work from _______________________

CHEMOTHERAPY: (Choose one ONLY)

If Creatinine Clearance is greater than or equal to 70 mL/min:

cladribine 0.14 mg/kg/day = _________ mg/day
  IV in 500 mL NS over 2 hours daily on Days 1 to 5.

cladribine 0.14 mg/kg/day = _________ mg/day SC* daily on Days 1 to 5.

Dose Modification if Creatinine Clearance 30 to less than 70 mL/min:

cladribine 0.14 mg/kg/day = _________ mg/day
  IV in 500 mL NS over 2 hours daily on Days 1 to 3.

cladribine 0.14 mg/kg/day = _________ mg/day SC* daily on Days 1 to 3.

*cladribine is provided as 1 mg/mL solution. SC administration requires several syringes to be administered therefore, IV route may be preferred.

RETURN APPOINTMENT ORDERS

Return in ______ week(s).

- □ Other tests:
- □ Consults:
- □ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: SIGNATURE: UC: