**PROTOCOL CODE: ULYMFBEX**

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</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:**

May proceed with doses as written if within 24 hours (for first treatment) or 7 days (for subsequent prescriptions)

ANC greater than $0.8 \times 10^9$ /L, fasting triglycerides less than or equal to $3.5 \text{ mmol/L}$ and AST and bilirubin less than or equal to $3$ times the upper limit of normal range.

Dose modification for:

- [ ] Hematology
- [ ] Other Toxicity: _____________________________

**TREATMENT:**

- bexarotene 300 mg/m²/day
- OR 400 mg/m²/day
- OR 200 mg/m²/day (circle one) = __________ mg PO once daily with a meal. (round off to nearest 75 mg)

Mitte: ____________ months

**RETURN APPOINTMENT ORDERS**

- [ ] Return in eight weeks for Doctor.
- [ ] Return in ______ week(s).

CBC & Diff, Platelets, AST, Bilirubin, Fasting Triglycerides, TSH and T4 every two months.

AST, Bilirubin at 1, 2 and 4 weeks after initiating treatment

- [ ] Fasting Triglycerides weekly x ________ weeks (until stabilization – usually first 2-4 weeks)

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**