PROTOCOL CODE: SMAJDT

DOCTOR'S ORDERS

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

DATE: **To be given:** **Cycle #:**

☐ Delay treatment _____ week(s)
Dose Modification/Delay for _____

Proceed with treatment based on blood work/ECG from_____

TREATMENT:

☐ **daBRAFenib** 150 mg PO twice daily for 30 days

☐ Dose modification: daBRAFenib ☐ 100 mg, ☐ 75 mg or ☐ 50 mg (select one) PO twice daily for 30 days

☐ **trametinib** 2 mg PO daily for 30 days (available in 30 tablet containers only: dispense in original container)

☐ Dose modification: trametinib ☐ 1.5 mg or ☐ 1 mg (select one) PO daily for 30 days

RETURN APPOINTMENT ORDERS

☐ **Cycle 1 only:** Return in 2 weeks for Doctor and skin toxicity assessment
☐ Return in 30 days for Doctor and Cycle # _____
☐ Last Treatment. Return in _____ week(s)

Baseline (prior to cycle #1): CBC and diff, platelets, creatinine, sodium, potassium, calcium, magnesium, alkaline phosphatase,-ALT, albumin, ECG, MUGA scan or echocardiogram (if not performed within a year)

Prior to each cycle: CBC and diff, platelets, creatinine, sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, albumin, LDH

ECG: every 4 weeks (prior to each cycle) for the first 3 cycles, then every 12 weeks
MUGA scan or echocardiogram: at week 8, then every 12 weeks

Dermatology Consults: at baseline (if not performed within a year) and at 8 weeks
Other Tests: ☐ ECG ☐ CT scan ☐ MRI ☐ echocardiogram ☐ glucose

☐ **Consults:**
- ☐ Dermatology Consult ☐ Ophthalmology Consult
- ☐ Pap smear in women
- ☐ Other Consults: _____

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: