

PROTOCOL CODE: SMAVVC

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DOCTOR'S ORDERS

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

DATE: _____ **To be given:** _____ **Cycle #:** _____ (One cycle = 4 weeks)

Delay treatment _____ week(s)

Dose Modification/Delay for _____

Proceed with treatment based on blood work/ECG from _____

TREATMENT:

vemURAFenib 960 mg or _____ mg PO twice daily for 4 weeks

cobimetinib 60 mg or _____ mg PO daily on days 1 to 21 and off for 7 days

RETURN APPOINTMENT ORDERS

Return in 4 weeks for Doctor and Cycle # _____

Last Treatment. Return in _____ week(s)

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

Prior to each cycle: CBC and diff, platelets, creatinine, [creatine kinase \(CK\)](#), sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, GGT, 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 4, then every 12 weeks

Dermatology Consults: at baseline (if not performed within a year) and at 8 weeks

Other Tests: ECG CT scan MRI MUGA 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: