**PROTOCOL CODE: USMAVDAB**

A BCCA “Compassionate Access Program” request form must be completed and approved prior to treatment and patients must have a BRAF V600 mutation.

### DOCTOR’S ORDERS

**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>
<tbody>
<tr>
<td></td>
<td></td>
<td>(One cycle = 4 weeks)</td>
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- [ ] 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 4 weeks

**Dose modification:**

- [ ] daBRAFenib 100 mg PO twice daily for 4 weeks
- [ ] daBRAFenib 75 mg PO twice daily for 4 weeks
- [ ] daBRAFenib 50 mg PO twice daily for 4 weeks

### 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, electrolytes, calcium, magnesium, alkaline phosphatase, ECG

**Prior to each cycle:** creatinine, electrolytes, calcium, magnesium, alkaline phosphatase

**ECG:** every 4 weeks (prior to each cycle) for the first 3 cycles, then every 12 weeks

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

**Other Tests:** [ ] ECG  [ ] CT scan  [ ] MRI

**Consults:**

- [ ] Dermatology Consults
- [ ] Pap smear in women
- [ ] Other Consults: ____________________________

- [ ] See general orders sheet for additional requests.

### DOCTOR’S SIGNATURE: ____________________________

**SIGNATURE:** ____________________________

**UC:** ____________________________