**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>
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- Delay treatment _____ week(s)
- Dose Modification/Delay for ________________________

**TREATMENT:**

- daBRAFenib 150 mg PO twice daily for 30 days
  - Dose modification: daBRAFenib 100 mg, 75 mg or 50 mg (circle 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 (circle 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, electrolytes, calcium, magnesium, alkaline phosphatase, AST, ALT, albumin, ECG, MUGA scan or echocardiogram (if not performed within a year)

**Prior to each cycle:** CBC and diff, platelets, creatinine, electrolytes, calcium, magnesium, alkaline phosphatase, AST, 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 Tests:** ________________________

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**