**PROTOCOL CODE: USMAVI**

## 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>Date of previous cycle:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Delay treatment _________ week(s)
- [ ] CBC & Diff, Platelets day of treatment.

May proceed with doses as written if within 14 days **ANC greater than or equal to 1 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L.**

Dose modifications for:  
- [ ] Hematology  
- [ ] other toxicity

### TREATMENT:

**iMAtinib 400 mg** PO daily

Dose modification: **300 mg OR 200 mg** (circle one) PO daily

**Mitte:** _________ month(s) supply (1 cycle = 1 month)

*Reminder: For patients on warfarin: Clinician to inform patient’s General Practitioner to monitor INR more closely (during treatment initiation and at dose changes of iMAtinib)*

### RETURN APPOINTMENT ORDERS

- [ ] Return in **four** weeks for Doctor and Cycle ____ for the first 3 months.
- [ ] Return in _____ weeks for Doctor and Cycles ________________.

**First 3 months of treatment:**

- CBC & Diff, Platelets on weeks 2, 4, 6, 8, 10, and 12
- Alk Phos, AST, LDH, Bilirubin, Creatinine on weeks 4, 8, and 12

**After 3 months of treatment:**

- CBC & Diff, Platelets, Alk Phos, AST, LDH, Bilirubin, Creatinine every 3 months

- [ ] Other Tests: ________________________________

- [ ] Consults: ________________________________

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**  
**SIGNATURE:**  
**UC:**