Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**PROTOCOL CODE: USMAVVC**

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>
<th>(One cycle = 4 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Delay treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dose Modification/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delay for</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proceed with</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment based on</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>blood work/ECG from</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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, creatinine kinase (CK or CPK), electrolytes, calcium, magnesium, alkaline phosphatase, AST, ALT, albumin, LDH, ECG, MUGA scan or echocardiogram (if not performed within a year)

**Prior to each cycle:** CBC and diff, platelets, creatinine, creatinine kinase (CK or CPK), electrolytes, calcium, magnesium, alkaline phosphatase, AST, 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:**