A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

Continuous treatment, one cycle = 4 weeks of regorafenib.

**DATE:** To be given: Cycle #: Date of Previous Cycle:

- Delay treatment ______ week(s)
- CBC & Diff day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L**

Dose modification for:  
- □ Hematology  
- □ Other Toxicity: _____________________________

Proceed with treatment based on blood work from _____________________________

**CHEMOTHERAPY:**

regorafenib 160 mg or 120 mg or 80 mg (circle one) PO daily for 21 days followed by 7 days rest

(round dose to the nearest 40 mg)

Mitte: ________________ tablets

**RETURN APPOINTMENT ORDERS**

- □ Return in _____ weeks for Doctor and Cycle ________
- □ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, **sodium, potassium**, Creatinine, Calcium, Phosphate, Bilirubin, Alkaline Phosphatase, ALT, and Urinalysis prior to each cycle

- □ TSH prior to each odd numbered cycle (ie 3, 5, 7, 9, etc)

If clinically indicated:  
- □ GGT  
- □ LDH  
- □ Tot. Prot  
- □ Albumin  
- □ TSH

- □ Other tests:

- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**