



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 and according to acceptable standards of care.

PROTOCOL CODE: LKCMLI

DOCTOR'S ORDERS			Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
DATE:	To be given:	Cycle #:			
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets, AST, ALT, Bilirubin, Serum Creatinine, BUN May proceed with doses as written if within 7 days of iMAtinib initiation, then within 10 days of dispensing the next cycle for first 6 months of therapy; thereafter, within 28 days of dispensing the next cycle. For chronic phase: ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L, bilirubin less than or equal to 3 x ULN, AST and/or ALT less than or equal to 5 x ULN For accelerated phase or blast crisis: ANC greater than or equal to 0.5 x 10⁹/L, Platelets greater than or equal to 10 x 10⁹/L, bilirubin less than or equal to 3 x ULN, AST and/or ALT less than or equal to 5 x ULN Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____					
CHEMOTHERAPY:					
<input type="checkbox"/> iMAtinib <input type="checkbox"/> 400 mg or <input type="checkbox"/> 600 mg or <input type="checkbox"/> 300 mg (select one) PO daily. ▪ Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months) OR <input type="checkbox"/> iMAtinib 400 mg PO BID Mitte: _____ months (1-month supply for first 6 months of therapy; may dispense 3-month supply after 6 months)					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in _____ weeks for Doctor.					
First Month: <input type="checkbox"/> CBC & Diff, Platelets, ALT, Bilirubin, Serum Creatinine, Uric Acid every _____ week(s) (range: 1-2 weeks)					
Months 2-6: CBC & Diff, Platelets, ALT, Bilirubin every month <input type="checkbox"/> Serum Creatinine, Uric Acid every _____ month(s)					
After 6 months: CBC & Diff, Platelets, ALT, Bilirubin, Serum Creatinine, Uric Acid <input type="checkbox"/> every month or <input type="checkbox"/> every 3 months <input type="checkbox"/> Peripheral blood analysis for quantitative RT-PCR (for BCR/ABL transcripts) every 3 months <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: