Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: UGUAVERD

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

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(s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **phosphate** day of treatment

May proceed with doses as written if within 96 hours **phosphate** **less than or equal to** **2.25 mmol/L.**

Dose modification for: _____

Proceed with treatment based on blood work from _____

TREATMENT:

erdafitinib 8 mg or _____ mg PO once daily continuously

Mitte: 1 cycle (28 days)

Refills: _____

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____
☐ Return in _____ weeks for Doctor and Cycle _____
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, phosphate, calcium, sodium, potassium prior to each cycle

phosphate, calcium, creatinine on Days 14 and 21 of Cycle 1

Weekly nursing assessment during Cycle 1

If clinically indicated:
☐ **LDH** ☐ **albumin** ☐ **magnesium** ☐ **urinalysis** ☐ **urea**
☐ **weekly nursing assessment for subsequent cycles**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: