



Provincial Health Services Authority

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: LKAMLQMTN

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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 #: _____ of _____
Date of Previous Cycle: _____		
☐ Delay treatment _____ week(s)		
May proceed with dose as written if within 96 hours ANC greater than or equal to $0.5 \times 10^9/L$, platelets greater than or equal to $25 \times 10^9/L$		
Dose modification for: ☐ QTc prolongation ☐ Other Toxicity: _____		
Proceed with treatment based on blood work from _____		
TREATMENT:		
☐ CYCLE #1:		
☐ quizartinib 26.5 mg PO once daily. When instructed by physician, take 53 mg PO once daily Dispense: <u>42 tablets</u>		
OR		
☐ quizartinib 26.5 mg PO once daily continuously Dispense: <u>28 tablets</u>		
OR		
☐ quizartinib 17.7 mg PO once daily continuously Dispense: <u>28 tablets</u>		
 ☐ CYCLE #2 and onward: ☐ Repeat in 4 weeks ☐ Repeat in 4 and 8 weeks		
☐ quizartinib 53 mg PO once daily continuously		
OR		
☐ quizartinib 26.5 mg PO once daily continuously		
Other dose modifications:		
☐ quizartinib 35.4 mg PO once daily continuously		
OR		
☐ quizartinib 17.7 mg PO once daily continuously		
Dispense: <u>28 days</u>		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC:



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DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in two weeks for Doctor on Cycle 1 Day 15 and in four weeks for Doctor and Cycle 2	
☐ Return in four weeks for Doctor and Cycle _____	
☐ Return in _____ weeks for Doctor and Cycles _____	
☐ Last Cycle. Return in _____ weeks for Doctor.	
ECG monitoring: weekly during Cycle 1, prior to Cycles 2 and 3, and every 3 rd cycle thereafter (i.e. prior to Cycle 6, 9, 12, etc.)	
Prior to each Cycle: CBC & Diff, creatinine, sodium, potassium, urea, magnesium, calcium	
If clinically indicated:	
☐ creatine kinase	
☐ total bilirubin	
☐ ALT	
☐ albumin	
☐ HBV viral load	
☐ Other tests:	
☐ Consults:	
☐ See general orders sheet for further orders	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: