PROTOCOL CODE: LUAJALE

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:

TREATMENT:

alectinib 600 mg PO twice daily

Dose modification if required:

- ☐ **alectinib 450 mg** PO twice daily
- ☐ **alectinib 300 mg** PO twice daily

Supply for: _____ days Repeat x _____

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor

Cycle 1:
CBC & Diff, alkaline phosphatase, ALT, total bilirubin, LDH and creatine kinase 2 weeks after starting treatment and prior to next cycle

Cycle 2 & 3:
CBC & Diff, alkaline phosphatase, ALT, total bilirubin, and LDH every 2 weeks and prior to next cycle

Cycle 4 onwards:
CBC & Diff, alkaline phosphatase, ALT, total bilirubin, and LDH prior to next doctor's visit

If clinically indicated:

☐ **chest X-ray** or ☐ **CT Scan (chest)**
☐ **ECG** ☐ **creatine kinase** ☐ **calcium** ☐ **potassium** ☐ **creatinine**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: