PROTOCOL CODE: UMLASMAVA

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

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, ALT, total bilirubin**

May proceed with doses as written if within 96 hours **platelets greater than or equal to 50 x 10^9/L.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

TREATMENT: ☐ Repeat in 4 weeks ☐ Repeat in 4 and 8 weeks

☐ **avapritinib 200 mg** PO once daily

Dose modification if required:

☐ **avapritinib 100 mg** PO once daily

☐ **avapritinib 50 mg** PO once daily

☐ **avapritinib 25 mg** PO once daily

Mitte: 30 days

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

Cycles 1 and 2, Day 15: **CBC & Diff, ALT, total bilirubin, creatinine**

Cycle 2 to 7: **ALT, total bilirubin, tryptase** prior to each cycle
CBC & Diff ☐ prior to each cycle OR ☐ every 2 weeks (select one)

Cycle 8 onwards: **ALT, total bilirubin** prior to each cycle
CBC & Diff ☐ prior to each cycle OR ☐ every 2 weeks (select one)

If clinically indicated:
☐ **tryptase** ☐ **creatinine** ☐ **alkaline phosphatase** ☐ **calcium** ☐ **phosphate**
☐ **sodium** ☐ **potassium** ☐ **albumin** ☐ **HBV viral load**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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