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: UCNVORA

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)

May proceed with doses as written if within 96 hours **ALT less than or equal to 3 times the upper limit of normal, total bilirubin less than 2 times the upper limit of normal.**

Dose modification for: ☐ Hepatotoxicity ☐ Other Toxicity _____

Proceed with treatment based on blood work from _____

TREATMENT:

vorasidenib 40 mg PO once daily

Dose modification:
☐ **vorasidenib 20 mg PO once daily**
☐ **vorasidenib 10 mg PO once daily**

Dispense: 30 days Repeat:_____

RETURN APPOINTMENT ORDERS

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

Cycles 1 to 2: **CBC & Diff, total bilirubin, ALT, alkaline phosphatase, GGT** every 2 weeks

Cycles 2 to 24, prior to each cycle: **CBC & Diff, total bilirubin, ALT, alkaline phosphatase, GGT**

Cycles 25 and onward, every third cycle: **CBC & Diff, total bilirubin, ALT, alkaline phosphatase, GGT**

If clinically indicated, throughout treatment:
☐ **creatinine** ☐ **random glucose**

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: