PROTOCOL CODE: LUAVALE

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:
Alk Phos, ALT, Bili, LDH and CPK 2 weeks after starting treatment and prior to next cycle

Cycle 2 & 3:
Alk Phos, ALT, Bili, and LDH every 2 weeks and prior to next cycle

Cycle 4 onwards:
Alk Phos, ALT, Bili, and LDH prior to next doctor's visit

Imaging (approx. every 4-8 weeks): ☐ **Chest X-ray** or ☐ **CT Scan (chest)**

If clinically indicated:

☐ **ECG** ☐ **CPK** ☐ **calcium** ☐ **potassium** ☐ **creatinine**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: