



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: LUAVOSIF

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 #:			
Date of Previous Cycle:					
TREATMENT:					
osimertinib 80 mg PO once daily					
Dose modification if required:					
<input type="checkbox"/> osimertinib 40 mg PO once daily					
Supply for: _____ days. Repeat x _____					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in _____ weeks for Doctor					
Alk Phos, ALT, Bili, LDH, potassium, calcium, magnesium at each doctor's visit					
Imaging (approx. every 4-8 weeks): <input type="checkbox"/> Chest X-ray or <input type="checkbox"/> CT Scan (chest) (select one)					
If clinically indicated:					
<input type="checkbox"/> CBC & Diff <input type="checkbox"/> creatinine <input type="checkbox"/> ECG					
<input type="checkbox"/> Muga Scan or <input type="checkbox"/> Echocardiogram (select one)					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: