PROTOCOL CODE: ULKAMLAMTN

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:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within **96 hours ANC greater than or equal to 0.5 x 10^9/L, Platelets greater than or equal to 25 x 10^9/L**

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

Proceed with treatment based on blood work from _____

TREATMENT:

azaCITIDine 300 mg PO once daily x 14 days on Days 1 to 14, then 14 days off.

Dose modification if required:

☐ **azaCITIDine 200 mg** PO once daily x 14 days on Days 1 to 14, then 14 days off.

☐ **azaCITIDine 200 mg** PO once daily x 7 days on Days 1 to 7, then 21 days off.

Start date: _____

Supply for _____ cycle(s).

RETURN APPOINTMENT ORDERS

☐ Return in **four weeks** for Doctor and Cycle _____

☐ Return in _____ weeks for Doctor and Cycle _____

CBC & Diff, Platelets, creatinine, urea, GGT, alkaline phosphatase, ALT, bili, LDH, albumin, sodium, potassium, chloride prior to each cycle

CBC & Diff, Platelets weekly for cycle 1, on Day 15 of cycle 2

If clinically indicated:

☐ **CBC & Diff, Platelets** on Day 15

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: