

**PROTOCOL CODE: SMAVVIS**

(Page 1 of 1)

Patient and Physician must be registered with the Erivedge® Pregnancy Prevention Program® (EPPP)

<b>DOCTOR'S ORDERS</b>	
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>	
<b>DATE:</b>	<b>To be given:</b> <b>Cycle #:</b> (One cycle = 4 weeks)
<input type="checkbox"/> Delay treatment _____ week(s) for _____	
Risk Classification (check one): <input type="checkbox"/> <b>Female of Childbearing Potential (FCBP)</b> <input type="checkbox"/> <b>Female of non-Childbearing Potential (FNCBP)</b> <input type="checkbox"/> <b>Male</b>	
<b>TREATMENT:</b>	
vismodegib 150 mg PO once daily	
<b>Mitte:</b>	
<input type="checkbox"/> FCBP : Dispense 28 capsules. (Maximum 28 capsules, no refills). Prescriptions must be dispensed within seven (7) days of the negative pregnancy test. <b>Date of last negative pregnancy test (no report needed) (dd/mm/yyyy):</b> _____	
<input type="checkbox"/> FNCBP or Male: Dispense <input type="checkbox"/> <b>28</b> capsules or <input type="checkbox"/> <b>56</b> capsules or <input type="checkbox"/> <b>84</b> capsules (select one). Maximum 3 cycles (84 capsules, no refills). Prescriptions must be dispensed within 28 days of the prescription date.	
<b>RETURN APPOINTMENT ORDERS</b>	
<b>Book to Erivedge® Pregnancy Prevention Program® Registered Physician only</b>	
<input type="checkbox"/> <b>FCBP:</b> Return in 4 weeks for Doctor and Cycle # _____.	
<input type="checkbox"/> <b>FNCBP or Male:</b> Return in _____ weeks for Doctor and Cycle(s) # _____.	
<input type="checkbox"/> Last Treatment. Return in _____ week(s)	
<b>Prior to each cycle:</b> CBC and diff, platelets	
<input type="checkbox"/> <b>Pregnancy blood test for female of childbearing potential (FCBP)</b> , every 4 weeks, less than or equal to 7 days prior to the next cycle	
<input type="checkbox"/> ALT <input type="checkbox"/> bilirubin <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> <b>Other tests</b> _____	
<input type="checkbox"/> <b>Consults:</b>	
<input type="checkbox"/> <b>See general orders sheet for additional requests.</b>	
<b>DOCTOR'S SIGNATURE: EPPP Registered only</b>	<b>SIGNATURE:</b>
<b>First name:</b>	<b>UC:</b>
<b>Last Name:</b>	
<b>Fax completed prescription to EPPP at 1-888-532-1198.</b>	
<b>Pharmacy requires a minimum of ONE business day for EPPP approval and dispensing</b>	