PROTOCOL CODE: LUAVBRI

DOCTOR'S ORDERS

Ht_____cm   Wt_____kg   BSA_____m²

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:

Start or restart cycle: (if possible, start early in the week)

☐ **brigatinib 90 mg** PO once daily for 7 days, then take **180 mg** once daily for 21 days. Do NOT increase dose until approval received.

OR

☐ **brigatinib _____ mg** PO once daily for 7 days, then take **_____ mg** once daily for 21 days. Do NOT increase dose until approval received.

Subsequent cycles:

☐ **brigatinib 180 mg** PO once daily. Supply for: _____ days

Dose modification if required:

☐ **brigatinib 120 mg** PO once daily. Supply for: _____ days (dose level -1)

☐ **brigatinib 90 mg** PO once daily. Supply for: _____ days (dose level -2)

☐ **brigatinib 60 mg** PO once daily. Supply for: _____ days (dose level -3)

RETURN APPOINTMENT ORDERS

☐ Return in 1 week for Doctor
☐ Return in _____ weeks for Doctor

Alk Phos, ALT, Bili, LDH every 2 weeks for the first 3 cycles

Alk Phos, ALT, Bili, LDH, creatine phosphokinase, lipase, blood pressure, heart rate at each doctor's visit

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

If clinically indicated: ☐ CBC and differential   ☐ sodium, potassium   ☐ magnesium   ☐ CEA   ☐ fasting glucose   ☐ creatinine
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE: _____

SIGNATURE:
UC: