PROTOCOL CODE: LUAVLOR

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:

lorlatinib 100 mg PO once daily

Dose modification if required:

- ☐ **lorlatinib 75 mg** PO once daily (dose level -1)
- ☐ **lorlatinib 50 mg** PO once daily (dose level -2)

Supply for: 30 days or _____ days. Repeat x _____

RETURN APPOINTMENT ORDERS

Return in **four** weeks for Doctor
Or ☐ Return in _____ weeks for Doctor

2 weeks after starting treatment**: total cholesterol, triglycerides**

Months 1 to 3, and at each physician visit:
total cholesterol, triglycerides, ALT, total bilirubin, alkaline phosphatase, LDH, ECG

If clinically indicated:
☐ **Chest X-ray or** ☐ **CT chest**
☐ **CBC & Diff, platelets** ☐ **fasting glucose** ☐ **hemoglobin A1C**
☐ **creatine kinase** ☐ **LDL** ☐ **HDL** ☐ **calcium** ☐ **albumin**
☐ **GGT** ☐ **lipase** ☐ **creatinine** ☐ **sodium** ☐ **potassium**
☐ **magnesium** ☐ **urea**
☐ Other tests:
☐ Consults:
☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: