PROTOCOL CODE: SMAJDT

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

☐ Delay treatment _____ week(s)

Dose Modification/Delay for _____

Proceed with treatment based on blood work/ECG from_____

TREATMENT:

☐ **daBRAFenib 150 mg** PO twice daily
- ☐ Dose modification: **daBRAFenib** ☐ **100 mg**, ☐ **75 mg** or ☐ **50 mg** (select one) PO twice daily

☐ **trametinib 2 mg** PO daily
- ☐ Dose modification: **trametinib** ☐ **1.5 mg** or ☐ **1 mg** (select one) PO daily

Supply for 30 days or for _____days (available in 30 tablet containers only: dispense in original container)
(1-month supply for first 3 months of therapy; may dispense 3-month supply after 3 months)

RETURN APPOINTMENT ORDERS

☐ Return in 4 weeks for Doctor and Cycle # _____
☐ Return in 8 weeks for Doctor and Cycle # _____
☐ Return in 12 weeks for Doctor and Cycle # _____
☐ Last Treatment. Return in _____ week(s)

First 3 months of treatment prior to each cycle: CBC & Diff, platelets, creatinine, sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, albumin, LDH

After 3 months of treatment prior to each physician visit: CBC & Diff, platelets, creatinine, sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, albumin, LDH

ECG: every 4 weeks (prior to each cycle) for the first 3 cycles, then every 12 weeks

MUGA scan or echocardiogram: at week 8, then every 12 weeks

Other Tests: ☐ ECG ☐ CT scan ☐ MRI ☐ echocardiogram ☐ random glucose

☐ **Consults:**
- ☐ Dermatology Consult ☐ Ophthalmology Consult
- ☐ Pap smear in women
- ☐ Other Consults: _____

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: