PROTOCOL CODE: UGUVHLBEL

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

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:

☐ Delay treatment _____ week(s)

May proceed with doses as written if within 96 hours: **hemoglobin greater than or equal to 80 g/L, total bilirubin less than or equal to 1.5 x ULN**

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

Proceed with treatment based on blood work from _____

TREATMENT:

☐ **belzutifan 120 mg** PO once daily.

Dose modification:

☐ **belzutifan 80 mg** PO once daily.

☐ **belzutifan 40 mg** PO once daily.

Mitte: 30 days or _____ days (maximum 90 days)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)

☐ Return in ____ weeks for Doctor and Cycle _____ (1 cycle = 4 weeks)

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, random glucose, pulse oximetry prior to each refill and prior to each doctor's visit

Cycles 1 and 2: **telephone nursing assessment every 2 weeks**

If clinically indicated:

☐ **serum HCG**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: