



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: ULUAVCER

Page 1 of 1

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 #:		
Date of Previous Cycle:				
TREATMENT:				
ceritinib 450 mg PO once daily				
Dose modification if required:				
<input type="checkbox"/> ceritinib 300 mg PO once daily (dose level -1)				
<input type="checkbox"/> ceritinib 150 mg PO once daily (dose level -2)				
Supply for: _____ days. Repeat x _____				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor				
Alk Phos, ALT, Bili, LDH two weeks after starting treatment				
Alk Phos, ALT, Bili, LDH at each doctor's visit				
Imaging (approx. every 4-8 weeks): <input type="checkbox"/> Chest X-ray or <input type="checkbox"/> CT Scan (chest)				
If clinically indicated:				
<input type="checkbox"/> ECG <input type="checkbox"/> creatinine <input type="checkbox"/> lipase <input type="checkbox"/> amylase				
<input type="checkbox"/> fasting glucose <input type="checkbox"/> sodium <input type="checkbox"/> potassium				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		