PROTOCOL CODE: ULUAVCER

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:

- ☐ **ceritinib 300 mg** PO once daily (dose level -1)
- ☐ **ceritinib 150 mg** PO once daily (dose level -2)

Supply for: _____ days. Repeat x _____

RETURN APPOINTMENT ORDERS

☐ 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): ☐ **Chest X-ray** or ☐ **CT Scan (chest)**

If clinically indicated:

☐ **ECG** ☐ **creatinine** ☐ **lipase** ☐ **amylase**

☐ **fasting glucose** ☐ **sodium** ☐ **potassium**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: