



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: ULUAVOSIF

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

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>		<b>Cycle #:</b>		
Date of Previous Cycle:					
TREATMENT:					
osimertinib 80 mg PO once daily					
Dose modification if required:					
<input type="checkbox"/> osimertinib 40 mg PO once daily					
Supply for: _____ days. Repeat x _____					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in _____ weeks for Doctor					
Alk Phos, ALT, Bili, LDH, potassium, calcium, magnesium at each doctor's visit					
Imaging (approx. every 4-8 weeks): <input type="checkbox"/> Chest X-ray or <input type="checkbox"/> CT Scan (chest) (select one)					
If clinically indicated:					
<input type="checkbox"/> CBC & Diff <input type="checkbox"/> creatinine <input type="checkbox"/> ECG					
<input type="checkbox"/> Muga Scan or <input type="checkbox"/> Echocardiogram (select one)					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests					
DOCTOR'S SIGNATURE:			SIGNATURE:		
			UC:		