



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: ULUAVOSI

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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:				
osimertinib 80 mg PO once daily				
Dose modification if required:				
<input type="checkbox"/> osimertinib 40 mg PO once daily				
Supply for: _____ days. Repeat x _____				
RETURN APPOINTMENT ORDERS				
<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)				
If clinically indicated:				
<input type="checkbox"/> CBC & Diff <input type="checkbox"/> ECG <input type="checkbox"/> creatinine <input type="checkbox"/> Muga Scan or Echocardiogram				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		