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: GILEN

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:

☐ Delay treatment _____ week(s) for ☐ **Hypertension** ☐ **Diarrhea** ☐ **Other**

☐ **CBC & Diff, platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than or equal to 30 mL/min, alkaline phosphatase, ALT less than or equal to 5 X ULN, total bilirubin less than or equal to 3 X ULN, urine protein less than 1 g/24 h**

Dose modification for: ☐ **Hematology** ☐ **Hypertension** ☐ **Diarrhea** ☐ **QTc prolongation** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

TREATMENT: One cycle = 30 days **Order in increments of 5 days (only available as 5-day supply unit)**

Treatment starting on _____ (date)

lenvatinib ☐ **12 mg or** ☐ **8 mg** (select one) **PO** *once* daily. Supply for: _____ days.

Or dose modification:

☐ **lenvatinib 4 mg PO** *once* daily. Supply for: _____ days.

☐ **lenvatinib 4 mg PO** *once every other day*. Supply for: _____ days.

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.
☐ Please book Nurse for BP monitoring q 2 weeks x _____.
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, platelets, creatinine, sodium, potassium, calcium, magnesium, ALT, alkaline phosphatase, total bilirubin, albumin, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle

Every two weeks for first 2 months: ALT, alkaline phosphatase, total bilirubin, albumin, blood pressure

If clinically indicated: ☐ **24 hour urine protein within 3 days prior to next cycle for laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+** ☐ **total protein** ☐ **GGT** ☐ **LDH** ☐ **BUN** ☐ **ECG** ☐ **INR** ☐ **Echocardiography** ☐ **AFP**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: