PROTOCOL CODE: HNOTVAN

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)

☐ **potassium, calcium, magnesium, blood pressure** day of treatment

May proceed with doses as written if within **96 hours: potassium, calcium, magnesium within normal limits, renal function according to protocol, blood pressure less than or equal to 140/90 mmHg**

Dose modification for: ☐ **Skin reactions** ☐ **Renal function** ☐ **Other**

Toxicity:_____

Proceed with treatment based on blood work from _____

TREATMENT:

☐ **vanDETanib 300 mg** PO once daily

Dose modification if required:

☐ **vanDETanib 200 mg** PO daily

☐ **vanDETanib 100 mg** PO daily

Mitte:_____ days (1 cycle=30 days)

RETURN APPOINTMENT ORDERS

Book to CAPRELSA (vandetanib) Restricted Distribution Program registered physician only

☐ **For the first cycle:** Return in two **and** four weeks for Doctor.

☐ **For Cycles 2 and 3 and after any dose change:** Return in **four** weeks for Doctor and Cycle # _____.

☐ Return in **eight** weeks for Doctor and Cycles # ____ and ____.

☐ Last Cycle. Return in _____ week(s).

DOCTOR'S SIGNATURE: **Restricted Distribution Program registered physician only**

SIGNATURE:

UC:

First name: **Last Name:**

Pharmacy may require a minimum of THREE business days for dispensing due to Restricted Distribution Program.

PROTOCOL CODE: HNOTVAN

DOCTOR'S ORDERS

DATE:

Two weeks after starting treatment and after any dose change:

CBC & Diff, Platelets, creatinine, potassium, calcium, magnesium, CEA, calcitonin, TSH, total bilirubin, ALT, alkaline phosphatase, ECG, blood pressure

Prior to each Doctor's visit:

CBC & Diff, Platelets, creatinine, potassium, calcium, magnesium, CEA, calcitonin, TSH, total bilirubin, ALT, alkaline phosphatase, ECG, blood pressure

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **LDH** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE: Restricted Distribution Program registered physician only

First name: **Last Name:**

SIGNATURE:

UC:

Pharmacy may require a minimum of THREE business days for dispensing due to Restricted Distribution Program