BC CANCER
Provincial Health Services Authority

PROTOCOL CODE: SMAVEB

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:**   **Cycle #:**

☐ Delay treatment _____ week(s)

Dose Modification/Delay for _____ _____

Proceed with treatment based on blood work/ECG from _____

TREATMENT:

encorafenib* 450 mg PO daily
    ☐ Dose modification if required: **encorafenib*** ☐ **300 mg** or ☐ **225 mg** (select one) PO daily

binimetinib 45 mg PO BID
    ☐ Dose modification if required: **binimetinib** ☐ **30 mg** PO BID

Supply for 30 days or for _____ days. (* Dispense encorafenib in original container.)
(1-month supply for first 3 months of therapy; may dispense 3-month supply after 3 months)

RETURN APPOINTMENT ORDERS

☐ Return in **4** weeks for Doctor and Cycle _____
☐ Return in **8** weeks for Doctor and Cycle _____
☐ Return in **12** weeks for Doctor and Cycle _____
☐ Last Treatment. Return in _____ week(s)

First 3 months of treatment prior to each cycle: CBC and differential, platelets, creatinine, creatine kinase, sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, GGT, albumin, LDH, blood pressure

After 3 months of treatment prior to each physician visit: CBC and differential, platelets, creatinine, creatine kinase, sodium, potassium, calcium, magnesium, alkaline phosphatase, ALT, GGT, albumin, LDH, blood pressure

☐ Quantitative beta-hCG blood test

ECG: every 4 weeks (prior to each cycle) for the first 12 weeks, then every 12 weeks

MUGA scan or echocardiogram: at week 8, then every 12 weeks

Other Tests: ☐ ECG ☐ CT scan ☐ MRI ☐ echocardiogram ☐ random glucose ☐ HbA1c

☐ **Consults:**
    ☐ Dermatology Consult   ☐ Ophthalmology Consult
    ☐ Pap smear in women
    ☐ Other Consults: _____

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: