

Doctor's Order Sheet

**encorafenib 450 mg -
binimetinib 45 mg Regimen**

ARIA Protocol Name: encorafenib binimetinib

Adult Chemotherapy - Medical Oncology

Treatment of BRAF V600 Mutation-Positive Unresectable or Metastatic Melanoma



CC8010 0621 12 2025

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____ **Cycle Duration: 28 days**

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- encorafenib 450 mg PO** daily on days 1 to 28
 - Dose modification: **encorafenib 300 mg PO** daily on days 1 to 28
 - Dose modification: **encorafenib 225 mg PO** daily on days 1 to 28
- binimetinib 45 mg PO** BID on days 1 to 28
 - Dose modification: **binimetinib 30 mg PO** BID on days 1 to 28

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.