PROTOCOL CODE: LYIBRU

DOCTOR'S ORDERS

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

DATE:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment
May proceed with doses as written if lab work is within 7 days of iBRUtinib initiation, then within 14 days of dispensing the next supply of iBRUtinib thereafter: **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____
Proceed with treatment based on blood work from _____

CHEMOTHERAPY: Continuous treatment

iBRUtinib ☐ **420 mg** or ☐ **280 mg** or ☐ **140 mg** (*select one*) PO daily

Mitte: _____days (maximum 90 days)

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks (maximum 12 weeks) for Doctor

Prior to each doctor's visit: **CBC & Diff, total bilirubin, ALT**

If clinically indicated:

☐ **PTT** ☐ **INR** ☐ **Creatinine** ☐ **HBV viral load**
☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **ECG**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: