**PROTOCOL CODE: LYVENETOR**  
(Post ramp-up, venetoclax PLUS riTUXimab combination therapy Cycles 1-6)  

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht: __________cm</th>
<th>Wt: __________kg</th>
<th>BSA: __________m²</th>
</tr>
</thead>
</table>

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

**DATE:**

<table>
<thead>
<tr>
<th>Week 6 onwards</th>
<th>Cycle # ____________</th>
</tr>
</thead>
</table>

- [ ] Delay treatment _____ week(s)
- [ ] **CBC and Diff** day of treatment  
  May proceed with doses as written if within 96 h **ANC greater than or equal to** 1.0 x 10^9/L, **Platelets greater than or equal to** 30 x10^9/L, **bilirubin less than or equal to** 3x ULN

Dose modification for:  
- [ ] **Hematology**  
- [ ] **Other Toxicity**

Proceed with treatment based on blood work from ___________________

**CHEMOTHERAPY:**

- [ ] **venetoclax 400 mg** (4 x 100 mg) once daily with food for ________ weeks

OR

- [ ] Dose modifications:

  - venetoclax ____________ mg PO once daily with food for ________ weeks

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
DATE:

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ___________________________.

For intravenous rituximab infusion:
diphenhydramine 50 mg PO prior to rituximab IV and then q 4 h if IV infusion exceeds 4 h
acetaminophen 650 mg to 975 mg PO prior to rituximab IV and then q 4 h if IV infusion exceeds 4 h

For subcutaneous rituximab injection:
diphenhydramine 50 mg PO prior to rituximab SC
acetaminophen 650 mg to 975 mg PO prior to rituximab SC

***Ensure patient continues venetoclax therapy***

**Have Hypersensitivity Reaction Medications and Protocol Available**

TREATMENT: (Continued)

CYCLE 1:
rituximab (first dose) 375 mg/m² x BSA = ___________ mg
IV in 250 to 500 mL NS.

Pharmacy to select rituximab IV brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>rituximab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Start at 50 mg/h. After 1 hour, increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs

For the first dose, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. Vital signs are not required, unless symptomatic.

FOR ALL SUBSEQUENT TREATMENTS

CYCLE # _________

☐ Patient tolerated a full dose of IV rituximab (no severe reactions requiring early termination) and can proceed to subcutaneous rituximab:

rituximab (RITUXAN SC) 1600 mg (fixed dose in 13.4 mL) subcutaneously into abdomen over 7 minutes.

Observe for 15 minutes after administration.

NB: During treatment with subcutaneous rituximab, administer other subcutaneous drugs at alternative injection sites whenever possible.

(Continued on page 3)
**DATE:**

**Have Hypersensitivity Reaction Medications and Protocol Available**

TREATMENT: (Continued)

☐ Patient did not tolerate a full dose of IV riTUXimab (experienced severe reactions requiring early termination) in the previous treatment and will continue with IV riTUXimab for this cycle:

\[
\text{riTUXimab } 500 \text{ mg/m}^2 \times \text{BSA} = \text{__________ mg}
\]

IV in 250 to 500 mL NS.

Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>riTUXimab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Infuse 50 mL (or 100 mL of 500 mL bag) of the dose over 30 minutes, then infuse the remaining 200 mL (or 400 mL of 500 mL bag) over 1 hour (total infusion time = 1 hour 30 min).

If flushing, dyspnea, rigors, rash, pruritus, vomiting, chest pain, any other new acute discomfort or exacerbation of any existing symptoms occur, stop infusion and page physician. Constant visual observation is not required.

RETURN APPOINTMENT ORDERS

☐ Return in four weeks or ______ weeks for Doctor and Cycle __________.

☐ Last Cycle. Return in ______ week(s) for Doctor and post ramp-up venetoclax alone treatment.

Prior to each doctor’s visit: CBC and diff, creatinine, bilirubin, ALT

If clinically indicated:

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: 

SIGNATURE: 

UC: