**PROTOCOL CODE:** LYVENETOR  
(Post ramp-up, venetoclax alone)

**DOCTOR’S ORDERS**  
Wt___________ kg

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

**DATE:**

Start Date of Cycle 1 Day 1 venetoclax+rituximab: ____________________________

- [ ] Delay treatment _____ week(s)
- [ ] CBC and Diff day of treatment

May proceed with doses as written if within 96h 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 (maximum 12 weeks)

OR

- [ ] Dose modifications:

  - venetoclax ____________ mg PO once daily with food for _________ weeks (maximum 12 weeks)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in _____ weeks for Doctor

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:**