PROTOCOL CODE: LYVENOB

(Post ramp-up, Cycles 3 to 12)

DOCTOR'S ORDERS Wt_____kg

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

DATE: **Cycle # _____, ____, and ____**

Date of previous cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 25 x 10^9/L, bilirubin less than or equal to 3 x ULN**

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

CHEMOTHERAPY:

venetoclax 400 mg (4 x 100 mg) PO once daily for _____ cycle(s) (maximum 3 cycles, 1 cycle = 4 weeks).
Pharmacy to dispense 1 cycle at a time

OR
Dose modifications:

☐ **venetoclax** _____ mg PO once daily for _____ cycle(s) (maximum 3 cycles, 1 cycle = 4 weeks)
Pharmacy to dispense 1 cycle at a time.

PREMEDICATIONS FOR oBINutuzumab INFUSION:

Patient to take own **acetaminophen** and **diphenhydrAMINE** supply. RN/Pharmacist to confirm:_____

30 minutes prior to infusion:
acetaminophen 650 mg to 975 mg PO
diphenhydrAMINE 50 mg PO

If previous reaction was grade 3, or if lymphocyte count greater than 25 x 10^9/L before treatment:
60 minutes prior to infusion:
☐ **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: LYVENOB

(Post ramp-up, Cycles 3 to 12)

DATE:

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

☐ **Cycle 3 to 6:**

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 1**.

Start at 100 mg/h. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

Vital signs prior to start of infusion, and as clinically indicated during and post infusion
Refer to protocol for resuming infusion following a reaction
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.

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks or _____ weeks for Doctor and Cycle # _____. Book chemo on Day 1.

☐ Last Cycle of chemo. Return in **four** weeks or ____ weeks for Doctor and Cycle # 7 for venetoclax alone treatment.

☐ Return in **four** weeks for Doctor and Cycle # _____.

☐ Return in **eight** weeks for Doctor and Cycle # _____ and_____.

☐ Return in **twelve** weeks for Doctor and Cycle # _____, _____ and_____.

☐ Last cycle. Return in_____ weeks for Doctor.

Prior to each cycle: **CBC & differential, creatinine, bilirubin, ALT**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**