BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

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** 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, total bilirubin less than or equal to 3 x ULN**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

TREATMENT:

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 supply of oral medications. RN/Pharmacist to confirm:_____
☐ If previous reaction to previous dose was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before Day 1 of current cycle, then 60 minutes prior to infusion: **dexamethasone 20 mg** IV

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

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

TREATMENT:

☐ **Cycle 3 to 6:**

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 1**.
If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster:
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.

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks or _____ weeks for Doctor and Cycle # _____. Book treatment on Day 1.
☐ Last Cycle. 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 & Diff, creatinine, total bilirubin, ALT**
If clinically indicated:
☐ **HBV viral load**
☐ Other tests:
☐ Consults:
☐ See general orders sheet for additional requests.

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