**PROTOCOL CODE: ULYFIBRU**

A **BC Cancer** “Compassionate Access Program” request form must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

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

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- [ ] 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 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 (*circle one*) PO daily continuously (round dose to the nearest 140 mg)

- Mitte: ________________ weeks (maximum 12 weeks)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in _____ weeks (maximum 12 weeks) for Doctor

**Baseline:** CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, PTT, INR, HBsAg, HBcoreAb

Prior to each doctor’s visit: **CBC & Diff, Platelets, Bilirubin, ALT**

If clinically indicated:  
- [ ] PTT  
- [ ] INR  
- [ ] ECG  
- [ ] Creatinine

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**