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

**DATE:**

☐ 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:**