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

<table>
<thead>
<tr>
<th>DATE:</th>
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</thead>
<tbody>
<tr>
<td>☐ Delay treatment _____ week(s)</td>
</tr>
<tr>
<td>☐ CBC &amp; Diff day of treatment</td>
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</tbody>
</table>

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 1.0 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 560 mg or 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

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:**