



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: ULYVENETO  
(Post ramp-up phase: Low, medium, high TLS risk)  
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A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

<b>DOCTOR'S ORDERS</b>		Wt _____ kg
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>		
DATE:		
<b>Week 6 onwards</b>		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC and Diff</b> day of treatment May proceed with doses as written if within 72 h <b>ANC greater than or equal to <math>1.0 \times 10^9/L</math>, Platelets greater than or equal to <math>30 \times 10^9/L</math>, bilirubin less than or equal to 3 x ULN</b>		
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b>		
Proceed with treatment based on blood work from _____		
<b>CHEMOTHERAPY:</b>		
<input type="checkbox"/> <b>venetoclax 400 mg</b> (4 x 100 mg) once daily for _____ weeks (maximum 12 weeks)		
OR		
<input type="checkbox"/> Dose modifications:		
<b>venetoclax</b> _____ mg PO once daily		
<b>Mitte:</b> _____ weeks		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in _____ weeks for Doctor		
Prior to each doctor's visit: <b>CBC and diff, creatinine, bilirubin, ALT</b>		
If clinically indicated:		
<input type="checkbox"/> <b>Other tests:</b>		
<input type="checkbox"/> <b>Consults:</b>		
<input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>	
	<b>UC:</b>	