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:** Week 6 onwards

- [ ] Delay treatment _____ week(s)
- [ ] CBC and Diff day of treatment

May proceed with doses as written if within 72 h ANC **greater than or equal to** 1.0 x 10^9/L, Platelets **greater than or equal to** 30 x 10^9/L, bilirubin **less than or equal to** 3 x ULN

Dose modification for:  
- [ ] Hematology  
- [ ] Other Toxicity

Proceed with treatment based on blood work from ______________

**CHEMOTHERAPY:**

- [ ] venetoclax **400 mg** (4 x 100 mg) once daily with food for _________ weeks (maximum 12 weeks)

OR  
- [ ] Dose modifications:

 venetoclax __________ mg PO once daily with food  

**Mitte:** ____________ weeks

**RETURN APPOINTMENT ORDERS**

- [ ] Return in _____ weeks for Doctor

Prior to each doctor’s visit: **CBC and diff, creatinine, bilirubin, ALT**

If clinically indicated:

- [ ] Other tests:
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**