**PROTOCOL CODE: ULYVENETO**  
(Ramp-up phase: Low or Medium TLS Risk)  
(Page 1 of 3)

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

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
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<tr>
<td>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</td>
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<table>
<thead>
<tr>
<th>DATE:</th>
<th>Start date of dose ramp-up (must be on a Thursday):</th>
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**Weeks 1 to 5 - Outpatient**

- **Delay treatment** ______ week(s)
- **CBC and Diff day of treatment, at baseline**

May proceed with doses as written if lab work is within 72 h of venetoclax initiation: **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 ______________________

**Tumor Lysis Prophylaxis:**
- **allopurinol 300 mg PO daily** – start at least 72 hours prior to first dose of venetoclax (patient’s own supply)
- Advise patient to drink 1.5 to 2 L of fluids daily during the first 5 weeks of therapy starting 48 hours prior to first dose of venetoclax

**CHEMOTHERAPY:**

- **Week 1:** **venetoclax 20 mg** (2 x 10 mg) once daily with food for 7 days
- **Week 2:** **venetoclax 50 mg** (1 x 50 mg) once daily with food for 7 days
- **Week 3:** **venetoclax 100 mg** (1 x 100 mg) once daily with food for 7 days
- **Week 4:** **venetoclax 200 mg** (2 x 100 mg) once daily with food for 7 days

**DO NOT** take day 2 dose on weeks 1 and 2, until approval received**

**DO NOT** start weekly dose increase, until approval received**

**AND**

- **Week 5:** **venetoclax 400 mg** (4 x 100 mg) once daily with food for 7 days

**DO NOT** start dose increase, until approval received**

**venetoclax** __________ mg PO once daily with food for __________ days (to last until next dose ramp up to start on a Thursday)

**OR**

- **Dose modifications:**

  **venetoclax** __________ mg PO once daily with food. **Start on** ________________ (enter date)

  **Mitte:** __________ weeks

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

UC:

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BC Cancer Provincial Preprinted Order ULYVENETO _Ramp-up_ low medium TLS risk
Created: 1 Sept 2019   Revised: 1 Oct 2019 (return appointments updated, allopurinol prescription added)
**PROTOCOL CODE: ULYVENETO**  
(Ramp-up phase: Low or Medium TLS Risk)  

**DATE:**

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
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<tr>
<td>Return in five weeks for Doctor</td>
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Baseline: **CBC and diff, potassium, calcium, magnesium, phosphate, uric acid, creatinine, urea, bilirubin, ALT, LDH, albumin, HBsAg, HBcoreAb. Pregnancy blood test in females of child-bearing potential.**

**ALL LABS FROM WEEKS 1 TO 5 MUST BE ORDERED AS STAT AT A LABORATORY WITH RAPID TURNOVER TIME (e.g. BC Cancer or hospital laboratory)**

Potassium, calcium, phosphate, uric acid, creatinine, LDH, albumin on the following days and times:

**Note: Day 7 labs must be on a Wednesday**

- Week 1 Day 1 at 12 noon
- Week 1 Day 2 at 8am
- Week 1 Day 7 before 12 noon
- Week 2 Day 1 at 12 noon
- Week 2 Day 2 at 8am
- Week 2 Day 7 before 12 noon
- Week 3 Day 7 before 12 noon
- Week 4 Day 7 before 12 noon

Telephone nursing assessment on day 6 of weeks 1, 2, 3 and 4

**Pharmacy booking as per centre specific standard on the following days:**
- Week 1 and Week 2: Days 1, 2 and 7
- Week 3 and Week 4: Day 7

Prior to each doctor’s visit (week 6 onwards): **CBC and diff, creatinine, bilirubin, ALT**

If clinically indicated:

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
PROTOCOL CODE: **ULYVENETO**  
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Fill prescription at a community pharmacy

**DATE:**

**allopurinol 300mg PO daily.** Start at least 72 hour prior to first dose of venetoclax.

Start date:______________ (Monday)

Mitte: __________ weeks

Reminder to patient: Drink 1.5 to 2 litres of fluid (8 glasses) every day for the first 5 weeks, starting 2 days before taking the first dose of venetoclax

**DOCTOR’S SIGNATURE:** ________________________________

Printed name: ________________________________

License number: ________________________________