

PROTOCOL CODE: LYMCABENDR **Cycles 15+**

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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 within 14 days **ANC greater than or equal to $0.5 \times 10^9/L$** , platelets **greater than or equal to $50 \times 10^9/L$**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

TREATMENT:

acalabrutinib 100 mg PO twice daily

Dose modification if required:

- ☐ **acalabrutinib 100 mg** PO once daily

Dispense: _____ days (maximum 90 days)

RETURN APPOINTMENT ORDERS

- ☐ Return in _____ weeks (maximum 12 weeks) for Doctor.

Prior to each doctor's visit: **CBC & Diff, total bilirubin, ALT**

If clinically indicated:

- ☐ **ECG**
☐ **creatinine**
☐ **PTT**
☐ **INR**
☐ **HBV viral load**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: