



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 and according to acceptable standards of care

PROTOCOL CODE: LYMCIV

Cycle 2 and onward

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DOCTOR'S ORDERS	Wt _____ kg Cycle # _____
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form	
DATE:	
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment	
May proceed with doses as written if within 96 hours ANC <u>greater than or equal to</u> $1.0 \times 10^9/L$, platelets <u>greater than or equal to</u> $50 \times 10^9/L$	
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity	
Proceed with treatment based on blood work from _____	
TREATMENT:	
CYCLES 2 to 24: <input type="checkbox"/> Repeat in 4 weeks <input type="checkbox"/> Repeat in 4 and 8 weeks	
iBRUtinib <input type="checkbox"/> 560 mg or <input type="checkbox"/> 420 mg or <input type="checkbox"/> 280 mg or <input type="checkbox"/> 140 mg (<i>select one</i>) PO daily	
venetoclax (select one):	
<input type="checkbox"/> venetoclax 400 mg (4 x 100 mg) PO once daily OR <input type="checkbox"/> venetoclax _____ mg PO once daily	
Dispense: 28 days	
CYCLE 25 and onward:	
iBRUtinib <input type="checkbox"/> 560 mg or <input type="checkbox"/> 420 mg or <input type="checkbox"/> 280 mg or <input type="checkbox"/> 140 mg (<i>select one</i>) PO daily	
Dispense: _____ days (maximum 90 days)	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC:



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DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in 4 weeks for Doctor and Cycle ____ <input type="checkbox"/> Return in ____ weeks for Doctor and Cycle ____ <input type="checkbox"/> Last Cycle. Return in _____ weeks	
Cycles 3 to 24, prior to each cycle: CBC & Diff, creatinine, total bilirubin, ALT Cycle 25 and onward, prior to each doctor's visit: CBC & Diff, creatinine, total bilirubin, ALT If clinically indicated: <input type="checkbox"/> HBV viral load <input type="checkbox"/> PTT <input type="checkbox"/> INR <input type="checkbox"/> echocardiogram <input type="checkbox"/> MUGA scan <input type="checkbox"/> ECG <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: