

PROTOCOL CODE: ULYWMIBRU

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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 lab work is within 7 days of iBRUtinib initiation, then within 14 days of dispensing the next supply of iBRUtinib thereafter: **ANC greater than or equal to $1.0 \times 10^9/L$, 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:

iBRUtinib ☐ **420 mg** or ☐ **280 mg** or ☐ **140 mg** (*select one*) PO daily

Mitte: _____ 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, serum protein electrophoresis, serum free light chain levels, immunoglobulin panel (IgA, IgG, IgM)**

If clinically indicated:

- ☐ **PTT** ☐ **INR** ☐ **creatinine** ☐ **HBV viral load**
☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **ECG**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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