

PROTOCOL CODE: LYVENOB
(Post ramp-up, Cycles 3 to 12)

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DOCTOR'S ORDERS	Wt _____ kg
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form	
DATE:	Cycle # _____, _____, and _____
Date of previous cycle: _____	
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment	
May proceed with doses as written if within 96 hours ANC greater than or equal to $1.0 \times 10^9/L$, Platelets greater than or equal to $25 \times 10^9/L$, total bilirubin less than or equal to 3 x ULN	
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____	
Proceed with treatment based on blood work from _____	
CHEMOTHERAPY:	
venetoclax 400 mg (4 x 100 mg) PO once daily for _____ cycle(s) (maximum 3 cycles, 1 cycle = 4 weeks). Pharmacy to dispense 1 cycle at a time	
OR	
Dose modifications:	
<input type="checkbox"/> venetoclax _____ mg PO once daily for _____ cycle(s) (maximum 3 cycles, 1 cycle = 4 weeks) Pharmacy to dispense 1 cycle at a time.	
PREMEDICATIONS FOR oBINutuzumab INFUSION:	
Patient to take own acetaminophen and diphenhydrAMINE supply. RN/Pharmacist to confirm: _____	
30 minutes prior to infusion:	
acetaminophen 650 mg to 975 mg PO diphenhydrAMINE 50 mg PO	
If previous reaction was grade 3, or if lymphocyte count greater than $25 \times 10^9/L$ before treatment:	
60 minutes prior to infusion:	
<input type="checkbox"/> dexamethasone 20 mg IV in 50 mL NS over 15 minutes	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC:

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DATE:	
Have Hypersensitivity Reaction Tray and Protocol Available	
<p>TREATMENT:</p> <p><input type="checkbox"/> Cycle 3 to 6:</p> <p>oBINutuzumab 1000 mg IV in 250 mL NS on Day 1.</p> <p>Start at 100 mg/h. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.</p> <p>Vital signs prior to start of infusion, and as clinically indicated during and post infusion Refer to protocol for resuming infusion following a reaction If flushing, dyspnea, rigors, rash, pruritus, vomiting, chest pain, any other new acute discomfort or exacerbation of any existing symptoms occur, stop infusion and page physician.</p>	
RETURN APPOINTMENT ORDERS	
<p><input type="checkbox"/> Return in four weeks or _____ weeks for Doctor and Cycle # _____. Book chemo on Day 1.</p> <p><input type="checkbox"/> Last Cycle of chemo. Return in four weeks or _____ weeks for Doctor and Cycle # 7 for venetoclax alone treatment.</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle # _____.</p> <p><input type="checkbox"/> Return in eight weeks for Doctor and Cycle # _____ and _____.</p> <p><input type="checkbox"/> Return in twelve weeks for Doctor and Cycle # _____, _____ and _____.</p> <p><input type="checkbox"/> Last cycle. Return in _____ weeks for Doctor.</p>	
<p>Prior to each cycle: CBC & differential, creatinine, total bilirubin, ALT</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: