PROTOCOL CODE: LYVENETOR

(Post ramp-up, venetoclax PLUS riTUXimab combination therapy Cycles 1-6)

DOCTOR'S ORDERS Ht: _____cm Wt_____kg BSA:_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE:

Week 6 onwards **Cycle # _____**

☐ Delay treatment _____ week(s)

☐ **CBC and Diff** day of treatment
May proceed with doses as written if within 96 h **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 30 x10^9/L, bilirubin less than or equal to 3x ULN**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

☐ **venetoclax 400 mg** (4 x 100 mg) PO once daily for _____ weeks

OR
☐ Dose modifications:

venetoclax _____ mg PO once daily for _____ weeks

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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(Post ramp-up, venetoclax PLUS riTUXimab combination therapy Cycles 1-6)

DATE:

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

For intravenous riTUXimab infusion:

diphenhydrAMINE 50 mg PO prior to **riTUXimab IV** and then q 4 h if IV infusion exceeds 4 h

acetaminophen 650 mg to 975 mg PO prior to **riTUXimab IV** and then q 4 h if IV infusion exceeds 4 h

For subcutaneous riTUXimab injection:

diphenhydrAMINE 50 mg PO prior to **riTUXimab subcutaneous**

acetaminophen 650 mg to 975 mg PO prior to **riTUXimab subcutaneous**

*****Ensure patient continues venetoclax threapy*****

****Have Hypersensitivity Reaction Medications and Protocol Available****

TREATMENT: (Continued)

CYCLE 1:

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS.

Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
riTUXimab		

Start at 50 mg/h. After 1 hour, increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs

For the first dose, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. Vital signs are not required, unless symptomatic.

FOR ALL SUBSEQUENT TREATMENTS

CYCLE # _____

☐ Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:

riTUXimab subcut (RITUXAN SC) 1600 mg (fixed dose in 13.4 mL) subcutaneously into abdomen over 7 minutes.
Observe for 15 minutes after administration.

NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.

(Continued on page 3)

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: LYVENETOR

(Post ramp-up, venetoclax PLUS riTUXimab combination therapy Cycles 1-6)

DATE:

****Have Hypersensitivity Reaction Medications and Protocol Available****

TREATMENT: (Continued)

☐ Patient did not tolerate a full dose of IV riTUXimab (experienced severe reactions requiring early termination) in the previous treatment and will continue with IV riTUXimab for this cycle:

riTUXimab 500 mg/m² x BSA = _____ mg
IV in 250 to 500 mL NS.

Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
riTUXimab		

Infuse 50 mL (or 100 mL of 500 mL bag) of the dose over 30 minutes, then infuse the remaining 200 mL (or 400 mL of 500 mL bag) over 1 hour (total infusion time = 1 hour 30 min).

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. Constant visual observation is not required.

RETURN APPOINTMENT ORDERS

☐ Return in four weeks or _____ weeks for Doctor and Cycle _____.

☐ Last Cycle. Return in _____ week(s) for Doctor and post ramp-up venetoclax alone treatment.

Prior to each cycle: **CBC and diff, creatinine, bilirubin, ALT**

If clinically indicated:

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: