

PROTOCOL CODE: ULKAMLAVEN
(Cycle 2 plus)

Page 1 of 1

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

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|---|---------------------|-----------------|-------------------|--------------------------|
| 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: | To be given: | Cycle #: | | |
| Date of Previous Cycle: _____ | | | | |
| <input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & diff, Platelets, serum creatinine, GGT, alkaline phosphatase, ALT, Bilirubin, LDH, Albumin, sodium, potassium, chloride, serum bicarbonate, urea, INR and PTT day of treatment <input type="checkbox"/> Patient not in remission: May proceed with doses as written regardless of the ANC. <input type="checkbox"/> Patient in remission: May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L and platelets greater than or equal to 50 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Drug Interaction <input type="checkbox"/> Other _____ Proceed with treatment based on blood work from _____ | | | | |
| PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO 30 minutes prior to azaCITIDine <input type="checkbox"/> prochlorperazine 10 mg PO 30 minutes prior to azaCITIDine <input type="checkbox"/> Other: _____ | | | | |
| CHEMOTHERAPY: azaCITIDine <input type="checkbox"/> 75 mg/m² OR <input type="checkbox"/> 50 mg/m² OR <input type="checkbox"/> 37.5 mg/m² x BSA = _____ mg subcutaneous daily for 7 days starting on Day 1 (date): _____. Alternate regimen: treatment may be interrupted by weekends. (May interrupt for more than 2 days but every effort should be made to avoid scheduling over long weekends) Administer doses greater than 4 mL as two syringes at two separate sites. venetoclax 400 mg PO once daily on Days 1 to 28 Dose modification: <input type="checkbox"/> venetoclax _____ mg PO once daily on Days _____ | | | | |
| RETURN APPOINTMENT ORDERS | | | | |
| <input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo x 7 days. | | | | |
| <input type="checkbox"/> Last Cycle. Return in _____ week (s). | | | | |
| Prior to each cycle: CBC & differential, platelets, creatinine, sodium, potassium, chloride, serum bicarbonate, bilirubin, ALT, alkaline phosphatase, GGT, LDH, INR and PTT Weekly on Days 8, 15, and 22: CBC & differential, platelets, creatinine, bilirubin, ALT, alkaline phosphatase, GGT, LDH <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests. | | | | |
| DOCTOR'S SIGNATURE: | | | SIGNATURE: | |
| | | | UC: | |