



Doctor's Order Sheet

idelalisib 150 mg

Regimen: Cycles 9+ (Part I)

ARIA Protocol Name: Ruxience (rituximab) idelalisib

Adult Chemotherapy - Hematology Oncology

Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL)

Name: _____

HCN: _____

Date of Birth: _____



CC6340 0444 01/2024

Allergies:

No Known

Date: DD/MONTH/YYYY Planned Administration Date: MM/YYYY

Cycle of Cycle Duration: **28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $0.5 \times 10^9/L$ and platelets **greater than or equal to** $25 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- idelalisib 150 mg PO** twice daily continuously
- Dose modification: **idelalisib 100 mg PO** twice daily continuously
- Mitte: 30 days

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- metoclopramide 10-20 mg PO** every 6 hours as needed
- sulfamethoxazole/trimethoprim 400/80 mg PO** once daily for duration of treatment and 2 to 6 months after completion of treatment
- Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.