



Doctor's Order Sheet

# Ruxience® (riTUXimab) 375 - acalabrutinib 100 mg

Regimen: Cycle 9+

ARIA Protocol Name: Ruxience (riTUXimab) acalabrutinib maintenance -  
Compassionate

Adult Chemotherapy - Hematology Oncology

Mantle Cell Lymphoma



CC8140 0634 01 2026

Weight: \_\_\_\_\_ kg    Height: \_\_\_\_\_ cm    Body Surface Area (BSA) = \_\_\_\_\_

**Allergies:**  **No Known**

Date: DD/MONTH/YYYY    Planned Administration Date: DD/MONTH/YYYY  
Cycle \_\_\_\_\_ of \_\_\_\_\_    Cycle Duration: **84 days**    Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to** 1 X 10<sup>9</sup>/L and platelets **greater than or equal to** 75 X 10<sup>9</sup>/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

- acalabrutinib 100 mg PO BID** on days 1 to 84  
 Dose modification: **acalabrutinib 100 mg PO** once daily on days 1 to 84

**HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):**

- metoclopramide 10-20 mg PO Q4-6H PRN**  
 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.