CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg - acalabrutinib 100 mg

Regimen: Cycle 1-8

ARIA Protocol Name: riTUXimab SC acalabrutinib maintenance - Compassionate Adult Chemotherapy - Hematology Oncology

Mantle Cell Lymphoma

Name:

HCN:

Date of Birth:

CC8110 0631 01 2026

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

Allergies: ☐ **No Known**

Date: _____ Planned Administration Date: _____

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

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **acetaminophen 650 mg PO** pre riTUXimab on day 1

☐ **cetirizine 10 mg PO** pre riTUXimab on day 1

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **riTUXimab-hyaluronidase,human 1400 mg SC** over 5 minutes on day 1

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.