



Doctor's Order Sheet

**riTUXimab-hyaluronidase**  
**1400 mg - acalabrutinib 100 mg**

Regimen: Cycle 9+

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

Mantle Cell Lymphoma



CC8120 0632 01 2026

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

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**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**  $1 \times 10^9/L$  and platelets **greater than or equal to**  $75 \times 10^9/L$ , 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.