



Doctor's Order Sheet
**venetoclax 400 mg -
azaCITIDine 75**

Regimen (Part II)

ARIA Protocol Name: Venetoclax Azacitidine (Post Cycle 1)
Adult Chemotherapy - Hematology Oncology
Acute Myeloid Leukemia

Name: _____

HCN: _____

Date of Birth: _____



CC8150 0635 01 2026

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

azaCITIDine 75 mg/m² X BSA = _____ mg

Dose modification: **azaCITIDine 75 mg/m² X BSA - _____ % = _____ mg**

SC on days 1 to 7

(May interrupt azaCITIDine for more than 2 days but every effort should be made to avoid scheduling over long weekends or statutory holidays during the week. If unavoidable, aim to deliver total of 7 days of treatment out of 10 consecutive days. If treatment must be interrupted for more than 2 days, **contact hematologist for direction.**)

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

venetoclax 400 mg

Dose modification: **venetoclax 400 mg - _____ % = _____ mg**

PO daily on days 1 to 28

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist

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.