BC Cancer Agency
CARE & RESEARCH

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: ULYALEM

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m^2**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff**, **Platelets** on day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.25 x 10^9/L, Platelets greater than or equal to 25 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

Diphenhydramine 50 mg PO prior to treatment

Acetaminophen 650 mg PO prior to treatment

Prednisone 10 mg PO 15-30 minutes prior to Alemtuzumab for the first two weeks.

☐ **Other:**

Have Hypersensitivity Reaction Tray and Protocol Available

TREATMENT:

Cycle_____:

Monday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) in 100 mL NS **IV** over 2 hours

Wednesday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) in 100 mL NS **IV** over 2 hours

Friday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) in 100 mL NS **IV** over 2 hours

OR

Cycle _____:

Monday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) **SC**

Wednesday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) **SC**

Friday: **Alemtuzumab** **3 mg / 10 mg / 30 mg** (circle one) **SC**

Observe patient for 60 minutes post administration; refer to protocol for monitoring. (see #3 under **Precautions** of protocol)

RETURN APPOINTMENT ORDERS

☐ Return in **one week** for Doctor and **week** _____ book chemo Monday, Wednesday and Friday.

☐ Last Cycle. Return in _____ week(s).

Weekly each Monday: CBC & Diff, Platelets, CMV-DNA by PCR

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: