



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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**Class II Drug:**

“Advanced stage indolent lymphoma at diagnosis”

For other indications, a BCCA “Compassionate Access Program” request form must be completed and approved prior to treatment.

PROTOCOL CODE: LYCVPR

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff and Platelets</b> day of treatment				
May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.2 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b>				
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>Ondansetron 8 mg</b> PO prior to treatment. <b>Dexamethasone 8 mg or 12 mg</b> (circle one) PO prior to treatment. <input type="checkbox"/> <b>Other:</b> _____				
<b>CHEMOTHERAPY:</b>				
<b>Vincristine 1.4 mg/m<sup>2</sup></b> x BSA = _____ mg <input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 15 mins.				
<b>Cyclophosphamide 1000 mg/m<sup>2</sup></b> x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour.				
<b>Prednisone 100 mg</b> PO daily in AM with food on days 1 to 5.				
<b>RITUXIMAB WITHIN 72 HOURS OF CVP</b>				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>Diphenhydramine 50 mg</b> PO prior to <b>Rituximab</b> and then q 4 h if the infusion exceeds 4 h <b>Acetaminophen 650-1000 mg</b> PO prior to <b>Rituximab</b> and then q 4 h if the infusion exceeds 4 h Prednisone as ordered for the LYCVP-R protocol				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	



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PROTOCOL CODE: LYCVP-R (Page 2 of 2)

Date:	
**Have Hypersensitivity Reaction Tray and Protocol Available**	
<p>TREATMENT: (continued)</p> <p>NOTE: If the peripheral blood lymphocyte count is above <math>30 \times 10^9/L</math>, the Rituximab should be omitted from that cycle.</p> <p><b>TREATMENT #1:</b></p> <p><b>Rituximab (first dose) <math>375 \text{ mg/m}^2 \times \text{BSA} = \underline{\hspace{2cm}}</math> mg</b>          IV in 250 to 500 mL NS within 72 hours after day 1 of CVP. Start at 50 mg/hour. After 1 hour, increase rate by 50 mg/hour every 30 minutes until rate = 400 mg/hour unless toxicity occurs.</p> <p>For the first dose, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. Vital signs are not required, unless symptomatic.</p> <p><b>FOR ALL SUBSEQUENT TREATMENTS:</b></p> <p><b>Rituximab (subsequent dose) <math>375 \text{ mg/m}^2 \times \text{BSA} = \underline{\hspace{2cm}}</math> mg</b>          IV in 250 to 500 mL NS within 72 hours after day 1 of CVP. Infuse 50 mL (or 100 mL of 500 mL bag) of the dose over 30 minutes, then infuse the remaining 200 mL (or 400 mL of 500 mL bag) over 1 hour.</p> <p>If flushing, dyspnea, rigors, rash, pruritus, vomiting, chest pain, any other new acute discomfort or exacerbation of any existing symptoms occur, stop infusion and page physician.</p> <p>For all subsequent doses, constant visual observation is not required.</p>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> or <b>four</b> weeks (circle one) for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<p><b>CBC &amp; Diff, platelets</b> prior to each cycle</p> <input type="checkbox"/> <b>Other tests:</b>	
<input type="checkbox"/> <b>Consults:</b>	
<input type="checkbox"/> <b>See general orders sheet for additional requests.</b>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: