



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.

PROTOCOL CODE: ULYRMTN

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

|   |                     |
|---|---------------------|
| DOCTOR'S ORDERS 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> |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff and Platelets</b> day of treatment<br>May proceed with doses as written if within 96 hours <b>ANC greater than or equal to <math>1.2 \times 10^9</math> /L, Platelets greater than or equal to <math>75 \times 10^9</math> /L</b><br><input type="checkbox"/> <b>Proceed with treatment based on blood work from _____</b>   |                     |
| PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.<br><b>Diphenhydramine 50 mg</b> PO prior to Rituximab and then q 4 h if the infusion exceeds 4 h<br><b>Acetaminophen 650-1000 mg</b> PO prior to Rituximab and then q 4 h if the infusion exceeds 4 h<br><input type="checkbox"/> <b>Prednisone 50 mg</b> PO prior to Rituximab PRN   |                     |
| <b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>   |                     |
| TREATMENT:<br><b>Rituximab <math>375 \text{ mg/m}^2</math> x BSA = _____ mg</b><br>IV in 250 to 500 mL NS over 1 hour 30 minutes. 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.<br><b>For maintenance dose # 1, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. For all subsequent maintenance doses (# 2-8), constant visual observation is not required. Vital signs are not required unless symptomatic.</b><br>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.<br><br>Patient may leave if stable when infusion completed. |                     |
| RETURN APPOINTMENT ORDERS   |                     |
| <input type="checkbox"/> Return in <b>three</b> months (calculate in months, not weeks) for Doctor and next dose of maintenance Rituximab.<br><input type="checkbox"/> Last dose. Return in _____ months  |                     |
| <b>CBC &amp; Diff, platelets</b> prior to each treatment.<br><br><input type="checkbox"/> <b>Other tests:</b><br><input type="checkbox"/> <b>Consults:</b><br><input type="checkbox"/> <b>See general orders sheet for additional requests.</b>   |                     |
| DOCTOR'S SIGNATURE:   | SIGNATURE:<br>UC:   |