



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: ULYRICE

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

<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, Platelets</b> day of treatment May proceed with doses as written if within 72 hours <b>ANC greater than or equal to 0.8 x 10<sup>9</sup>/L, Platelets greater than or equal to 75 x 10<sup>9</sup>/L, Creatinine Clearance greater than 60 mL/min</b>  Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ Proceed with treatment based on blood work from _____					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>Ondansetron</b> 8 mg PO pre-chemotherapy daily <b>Dexamethasone</b> 12 mg PO pre-chemotherapy daily <input type="checkbox"/> <b>Other:</b> _____					
<b>Instruct patient to dipstick urine for blood prior to chemo – daily and with each void at home. Patient to call physician immediately if positive for blood. Patient to call physician immediately if they become drowsy. Chemo Room RN to ensure patient has been taught to do urine dipstick for blood. Chemo Room RN to ensure patient has tested urine for blood prior to each dose.</b>					
<b>CHEMOTHERAPY:</b>  <b>Ifosfamide</b> 1667 mg/m <sup>2</sup> x BSA = _____ mg with <b>Mesna</b> 1667 mg/m <sup>2</sup> x BSA = _____ mg IV in 1000 mL D5W over 2 hours on day 1,2,3 (total dose per cycle for each drug = 5000 mg/m <sup>2</sup> )  <b>Mesna</b> 2000 mg PO 2h and 4h after completion of Ifosfamide on day 1,2,3  <b>Carboplatin</b> AUC 5 x (Creatinine clearance + 25) = _____ mg IV in 250 mL D5W over <b>1 hour</b> on day 1 ONLY. (Maximum dose = 800 mg)  <b>Etoposide</b> 100 mg/m <sup>2</sup> /day x BSA = _____ mg IV in 500 mL NS over <b>45</b> minutes daily on day 1,2,3					
<b>EMERGENCY DRUGS FOR MANAGEMENT OF ETOPOSIDE TOXICITY:</b> <b>Hydrocortisone 100 mg IV prn / Diphenhydramine 50 mg IV prn</b>					
DOCTOR'S SIGNATURE:				SIGNATURE:	
				UC:	



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DATE: _____	
<b>***Have Hypersensitivity Reaction Tray and Protocol Available***</b>	
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.	
<b>Diphenhydramine</b> 50 mg PO prior to Rituximab and then q4h during Rituximab infusion.	
<b>Acetaminophen</b> 650-1000 mg PO prior to Rituximab and then q4h during Rituximab infusion.	
TREATMENT:	
<b>Rituximab (first dose)</b> 375 mg/m <sup>2</sup> x BSA = _____ mg	
IV in 250 to 500 mL NS within 72 hours of day 1 of ICE.	
NOTE: If the peripheral blood lymphocyte count is above 30 x 10 <sup>9</sup> /L, the Rituximab should not be given.	
<b>TREATMENT #1:</b>	
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.	
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.	
If flushing, dyspnea, rigors, rash, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.	
<b>FOR ALL SUBSEQUENT TREATMENTS:</b>	
<b>Rituximab (subsequent dose)</b> 375 mg/m <sup>2</sup> x BSA = _____ mg	
IV in 250 to 500 mL NS within 72 hours of day 1 of ICE. 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.	
If flushing, dyspnea, rigors, rash, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.	
For all subsequent doses, constant visual observation is not required.	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ Book chemo x 3 days	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<b>CBC &amp; Diff, Platelets, Total Bilirubin, Creatinine, LDH</b> prior to each cycle	
<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: