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: LYCHLRR

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

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 day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 80 x 10⁹/L.

Dose modification for:  
- Hematology
- Other Toxicity

Proceed with treatment based on blood work from ______________

TREATMENT:

Schedule 1:

- Chlorambucil 0.4 mg/kg x Wt = _________ mg PO on day 1 and day 15
  - Dose Modification: _______ mg/kg x Wt = _________ mg
  
  Round each dose to the nearest 2 mg.
  Administer on an empty stomach.

OR

Schedule 2:

- Chlorambucil 10 mg/m² x BSA = _________ mg PO on days 1 to 7
  - Dose Modification: ______% = ______ mg/m² x BSA = _________ mg
  
  Round each dose to the nearest 2 mg.
  Administer on an empty stomach.
  (May divide dose into 2-3 subdoses each day to improve tolerance)

NOTE: Chlorambucil may be given without rITUXimab after cycle 6.

(Continued on Page 2)

DOCTOR’S SIGNATURE: SIGNATURE:

UC:
**Have Hypersensitivity Reaction Tray and Protocol Available**

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm______________.

For intravenous rituximab infusion:
diphenhydramine 50 mg PO prior to rituximab IV and then q 4 h if IV infusion exceeds 4 h
acetaminophen 650 mg to 975 mg PO prior to rituximab IV and then q 4 h if IV infusion exceeds 4 h

For subcutaneous rituximab injection:
diphenhydramine 50 mg PO prior to rituximab SC
acetaminophen 650 mg to 975 mg PO prior to rituximab SC

☐ Other

**TREATMENT:** (continued)

TREATMENT #1:
rituximab (first dose) 375 mg/m² x BSA = __________ mg
IV in 250 to 500 mL NS within 72 hours after Day 1 of chlorambucil.
Start at 50 mg/h. After 1 hour, increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs.

Pharmacy to select rituximab IV brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>rituximab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**
**TREATMENT: (Continued)**

**FOR ALL SUBSEQUENT TREATMENTS:**

- **Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:**

  riTUXimab *(RITUXAN SC)* 1400 mg *(fixed dose in 11.7 mL)* subcutaneously into abdomen over 5 minutes.

  Observe for 15 minutes after administration.

  NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.

- **Patient did not tolerate a full dose of IV riTUXimab (experienced severe reactions requiring early termination) in the previous treatment and will continue with IV riTUXimab for this cycle:**

  riTUXimab *(subsequent dose)* 375 mg/m$^2$ x BSA = ______ mg

  IV in 250 to 500 mL NS. 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.

Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190

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<tr>
<td>riTUXimab</td>
<td></td>
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</tbody>
</table>

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.

For all subsequent doses, constant visual observation is not required.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**
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**PROTOCOL CODE: LYCHLRR**

<table>
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<tr>
<th>Return Appointment Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Return in <strong>four</strong> weeks for Doctor and Cycle _________. (Book chemo for riTUXimab treatment only.)</td>
</tr>
<tr>
<td>☐ RTC in <strong>four</strong> weeks for Doctor and Cycle _________. (No riTUXimab treatment)</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in ______ week(s).</td>
</tr>
</tbody>
</table>

**CBC & Diff, Platelets** prior to each cycle

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**Doctor's Signature:**

**Signature:**

**UC:**

Date:

RETURN APPOINTMENT ORDERS

BC Cancer Agency Provincial Preprinted Order **LYCHLRR**

Created: 1 Nov 2014  Revised: 1 Aug 2020 (biosimilar table inserted)