

PROTOCOL CODE: LYCHOPO Page 1 of 3
(Induction Cycle 1)

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: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment		
May proceed with doses as written if within 96 hours ANC greater than or equal to 0.8 x 10⁹/L and platelets greater than or equal to 80 x 10⁹/L		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____		
Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply of oral medications. RN/Pharmacist to confirm _____.		
Day 1:		
PREMEDICATIONS FOR DOXOrubicin, vinCRiStine, and cyclophosphamide:		
dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to treatment.		
and select ONE of the following:		
<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to treatment	
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to treatment ondansetron 8 mg PO 30 to 60 minutes prior to treatment	
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment	
<input type="checkbox"/> hydrocortisone 100 mg IV prior to etoposide		
<input type="checkbox"/> diphenhydrAMINE 50 mg IV prior to etoposide		
Day 2:		
PREMEDICATIONS FOR oBINutuzumab INFUSION:		
60 minutes prior to infusion: dexamethasone 20 mg IV		
30 minutes prior to infusion: acetaminophen 650 to 975 mg PO and diphenhydrAMINE 50 mg PO		
Day 8 and Day 15:		
PREMEDICATIONS FOR oBINutuzumab INFUSION:		
<input type="checkbox"/> If reaction to previous oBINutuzumab was Grade 3, or if lymphocyte count greater than 25 x 10 ⁹ /L before Cycle 1 Day 1, then 60 minutes prior to infusion: dexamethasone 20 mg IV		
30 minutes prior to infusion: acetaminophen 650 to 975 mg PO and diphenhydrAMINE 50 mg PO		
<input type="checkbox"/> Other: _____		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC:

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Date:

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

TREATMENT:

Days 1 to 5:

predniSONE 45 mg/m² x BSA = _____ mg PO daily in AM on Days 1 to 5. (Round dose to nearest 25 mg)

Day 1:

DOXOrubicin 50 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV push on **Day 1**.

vinCRistine 1.4 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 50 mL NS over 15 minutes on **Day 1**.

cyclophosphamide 750 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour on **Day 1**.

If cardiac dysfunction:

Omit **DOXOrubicin**.

Give **etoposide 50 mg/m² x BSA = _____ mg**

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 45 minutes on **Day 1** (Use non-DEHP tubing with in-line filter), AND

etoposide 100 mg/m² x BSA x (_____ %) = _____ mg PO on Days 2 and 3 (Round dose to nearest 50 mg)

If total bilirubin greater than 85 micromol/L:

Omit **DOXOrubicin**.

Change **cyclophosphamide to 1100 mg/m² x BSA = _____ mg**

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour on **Day 1**.

Day 2:

oBINutuzumab 1000 mg IV in 250 mL NS on Day 2.

Start infusion at **50 mg/h**; after 30 minutes, increase by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

For first dose, constant visual observation during dose increases and for 30 minutes after infusion completed. Vital signs not required unless symptomatic.

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.

Days 8 and 15:

oBINutuzumab 1000 mg IV in 250 mL NS on Days 8 and 15.

If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster: Start infusion at **100 mg/h** for 30 minutes; if tolerated, may escalate rate in increments of 100 mg/h every 30 minutes until rate = 400 mg/h. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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Date:	
RETURN APPOINTMENT ORDERS	
Return in <u>three</u> weeks for Doctor and Cycle 2. Book <u>treatment</u> for Day 1 only.	
CBC & Diff prior to Day 1 of cycle 2 If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> ALT <input type="checkbox"/> total bilirubin <input type="checkbox"/> HBV viral load <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: