



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: LYCHOPRMTX**

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<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</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC</b> greater than or equal to <b>0.8 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>dexamethasone</b> <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) PO 30 to 60 minutes prior to treatment and <b>select ONE</b> of the following:				
<input type="checkbox"/>	<b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to treatment			
<input type="checkbox"/>	<b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to treatment <b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to treatment			
<input type="checkbox"/>	<b>netupitant-palonosetron 300 mg-0.5 mg</b> PO 30 to 60 minutes prior to treatment			
<input type="checkbox"/> <b>hydrocortisone 100 mg</b> IV prior to etoposide <input type="checkbox"/> <b>diphenhydramine 50 mg</b> IV prior to etoposide <input type="checkbox"/> <b>Other:</b> _____				
<b>CHEMOTHERAPY:</b> <b>prednisONE 45 mg/m<sup>2</sup> x BSA = _____ mg</b> PO daily in AM on Days 1 to 5. (Round dose to nearest 25 mg) <b>DOXOrubicin 50 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV push on Day 1. <b>vinCRistine 1.4 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 15 minutes on Day 1. <b>cyclophosphamide 750 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour on Day 1.				
<b><u>If cardiac dysfunction:</u></b> Omit <b>DOXOrubicin</b> . Give <b>etoposide 50 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> 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), <b>AND</b> <b>etoposide 100 mg/m<sup>2</sup> x BSA x ( _____ %) = _____ mg</b> PO on Days 2 and 3 (Round dose to nearest 50 mg)				
<b><u>If Bilirubin greater than 85 micromol/L:</u></b> Omit <b>DOXOrubicin</b> . Change <b>cyclophosphamide to 1100 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour on Day 1.				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>  <b>UC:</b>

# **PROTOCOL CODE: LYCHOPRMTX**

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**Date:**

## **RITUXIMAB WITHIN 72 HOURS OF CHOP**

**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

**predniSONE** as ordered for the LYCHOPRMTX protocol

### **For subcutaneous riTUXimab injection:**

**diphenhydrAMINE 50 mg** PO prior to **riTUXimab subcutaneous**

**acetaminophen 650 mg to 975 mg** PO prior to **riTUXimab subcutaneous**

**predniSONE** as ordered for the LYCHOPRMTX protocol

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

### **TREATMENT: (Continued)**

riTUXimab IV or subcutaneous may be given before or after chemotherapy, but within 72 hours after Day 1 of CHOP

#### **TREATMENT #1:**

**riTUXimab (first dose) 375 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg**

IV in 250 to 500 mL NS.

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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
riTUXimab		

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.

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

#### **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 subcut (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.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

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**Date:**

### TREATMENT: (Continued)

☐ 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 375 mg/m<sup>2</sup> 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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
riTUXimab		

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.

**\*\*SEE REGIONAL INPATIENT ORDERS FOR HIGH DOSE METHOTREXATE TREATMENT\*\***

### RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle \_\_\_\_\_, Day 1 as outpatient. Admit for cycle \_\_\_\_\_, Day \_\_\_\_\_ of high dose methotrexate as inpatient.

☐ Last Cycle. Return in \_\_\_\_\_ week(s).

**CBC & Diff** prior to Day 1 of each cycle

If clinically indicated:

☐ **total bilirubin**

☐ **LDH**

☐ **creatinine**

☐ **ALT**

☐ **HBV viral load** every 3 months

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**