**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<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 #: ________________________

- [ ] 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 0.8 x 10⁹/L

Dose modification for:  
- [ ] Hematology
- [ ] Other Toxicity

Proceed with treatment based on blood work from ________________________

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

- [ ] dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment
- [ ] select ONE of the following:
  - [ ] ondansetron 8 mg PO 30 to 60 minutes prior to treatment
  - [ ] aprepitant 125 mg PO 30 to 60 minutes prior to treatment
  - [ ] ondansetron 8 mg PO 30 to 60 minutes prior to treatment
  - [ ] netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment
- [ ] prochlorperazine 10 mg PO prn
- [ ] hydrocortisone 100 mg IV prior to etoposide
- [ ] diphenhydrAMINE 50 mg IV prior to etoposide
- [ ] Other:

**CHEMOTHERAPY:**

- [ ] predniSONE 45 mg/m² x BSA = _________mg PO daily in AM with food on day 1 to 5.
  (Round dose to nearest 25 mg)
- [ ] 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 day 2 and 3 (Round dose to nearest 50 mg)

If 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.

**EMERGENCY DRUGS FOR MANAGEMENT OF ETOPOSIDE TOXICITY:**

- [ ] hydrocortisone 100 mg IV prn / diphenhydrAMINE 50 mg IV prn

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**

---

BC Cancer Provincial Preprinted Order LYCHOPRMTX

Created: 1 Jun 2014  Revised: 1 Aug 2020 (biosimilar table inserted)
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 SC
acetaminophen 650 mg to 975 mg PO prior to rITUXimab SC
predniSONE as ordered for the LYCHOPRMTX protocol

**Have Hypersensitivity Reaction Tray and Protocol Available**

TREATMENT: (Continued)
rITUXimab IV or SC may be given before or after chemotherapy, but within 72 hours after day 1 of CHOP

TREATMENT #1:
rITUXimab (first dose) 375 mg/m\(^2\) x BSA = __________ mg

IV in 250 to 500 mL NS.

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>

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 **(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: 

UC:
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/m² 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

<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>

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, platelets prior to day 1 of each cycle

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: SIGNATURE:

UC: