PROTOCOL CODE: LYCHOPR

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 #:_____of_____**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 96 hours **ANC** greater than or equal to **0.8 x 10^9/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** (select one) PO 30 to 60 minutes prior to treatment

and **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

☐ **hydrocortisone 100 mg** IV prior to etoposide
☐ **diphenhydrAMINE 50 mg** IV prior to etoposide
☐ **Other:**

CHEMOTHERAPY:

predniSONE 45 mg/m^2 x BSA =_____mg PO daily in AM on day 1 to 5.
(Round dose to nearest 25 mg)

DOXOrubicin 50 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push on day 1.

vinCRIStine 1.4 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 50 mL NS over 15 minutes on day 1.

cyclophosphamide 750 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 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/m^2** x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 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/m^2 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/m^2** x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour on day 1.

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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 LYCHOP-R 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 LYCHOP-R 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^2 x BSA = _____ mg
IV in 250 to 500 mL NS. 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

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

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:** **UC:**

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^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

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.

RETURN APPOINTMENT ORDERS

For Cycle #1, book chemo on days 1 and 2.

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff prior to each cycle

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: