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:

☐ 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 1.2 x 10^9/L, platelets greater than or equal to 80 x 10^9/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.

OR

Schedule 2:

chlorambucil 10 mg/m^2 x BSA = _____ mg PO on **Days 1 to 7**

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

Round each dose to the nearest 2 mg.
(May divide dose into 2-3 subdoses each day to improve tolerance)

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

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

DATE:

****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 subcutaneous**

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

☐ **Other**

TREATMENT: (continued)

CYCLE #1:

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg

IV in 250 to 500 mL NS within 72 hours after Day 1 of chlorambucil.

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 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.

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

DATE:

TREATMENT: (Continued)

riTUXimab for Cycle 2 and 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) 1600 mg (fixed dose in 13.4 mL) subcutaneously into abdomen over 7 minutes on Day 1 of chlorambucil. Observe for 15 minutes after administration.

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

OR

☐ 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 500 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS on Day 1 or 2 whenever possible, but not later than 72 hours after Day 1 of chlorambucil

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		

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. (total infusion time = 1 hour 30 min)

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. Constant visual observation is not required.

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

Date:	
RETURN APPOINTMENT ORDERS	
☐ Return in **four** weeks for Doctor and Cycle _____. (Book chemo for riTUXimab treatment only.) ☐ RTC in **four** weeks for Doctor and Cycle _____.(No riTUXimab treatment) ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff prior to each cycle If clinically indicated: ☐ **ALT** ☐ **HBV viral load** every 3 months ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**