**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
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**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 and Platelets day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 100 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 ________________.

- **ondansetron 8 mg** PO prior to treatment
- **dexamethasone 8 mg or 12 mg** (circle one) PO prior to treatment
- □ Other:

**CHEMOTHERAPY:**

- **predniSONE 100 mg** PO daily in AM with food on days 1 to 5.

- **vinCRIStine 1.4 mg/m² x BSA = ______ mg**
  - □ Dose Modification: ______% = ______ mg/m² x BSA = ___________ mg
  - IV in 50 mL NS over 15 mins.

- **cyclophosphamide 1000 mg/m² x BSA = ___________mg**
  - IV in 100 to 250 mL NS over 20 minutes to 1 hour.

**RITUXIMAB WITHIN 72 HOURS OF CVP**

**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 LYCLLCVPR 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 LYCLLCVPR protocol

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

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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](http://www.bccancer.bc.ca) and according to acceptable standards of care.
**Have Hypersensitivity Reaction Tray and Protocol Available**

**TREATMENT: (continued) CYCLE 1 ONLY:**

riTUXimab (first dose) \(375 \text{ mg/m}^2 \times \text{BSA} = \underline{\phantom{1000}} \text{mg}\)

IV in 250 to 500 mL NS within 72 hours after day 1 of CVP. Start at 50 mg/hour.
After 1 hour, increase rate by 50 mg/hr 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.

riTUXimab for CYCLES 2-8:

☐ Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:

riTUXimab (subsequent dose) \(1600 \text{ mg (fixed dose in 13.4 mL) subcutaneously}\) into abdomen over 7 minutes.
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 (subsequent dose) \(500 \text{ mg/m}^2 \times \text{BSA} = \underline{\phantom{1000}} \text{mg}\)

IV in 250 to 500 mL NS on day 1. 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.

**RETURN APPOINTMENT ORDERS**

☐ Return in **three** or **four** weeks (circle one) for Doctor and Cycle _________

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

**CBC & Diff, platelets** prior to each cycle

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**