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 and according to acceptable standards of care

PROTOCOL CODE: LYCVPO

(Induction Cycle 1)

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 0.8 x 10^9/L and 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 _____

PREMEDICATIONS: Patient to take own supply of oral medications. RN/Pharmacist to confirm _____.

Day 1:

PREMEDICATIONS FOR vinCRIStine and cyclophosphamide:

ondansetron 8 mg PO prior to treatment

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO prior to treatment.

Day 2:

PREMEDICATIONS FOR oBINutuzumab INFUSION:

60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** PO

Day 8 and Day 15:

PREMEDICATIONS FOR oBINutuzumab INFUSION:

☐ If reaction to previous oBINutuzumab was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before Cycle 1 Day 1, then 60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** PO

☐ **Other:**

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

PROTOCOL CODE: LYCVPO

(Induction Cycle 1)

DATE:

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

TREATMENT:

Days 1 to 5:

predniSONE 100 mg PO daily in AM on **Days 1 to 5**.

Day 1:

vinCRIStine 1.4 mg/m² x BSA =_____mg on **Day 1.**

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 50 mL NS over 15 mins.

cyclophosphamide 1000 mg/m² x BSA = _____mg on **Day 1.**

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour.

Day 2:

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 2**.

Start infusion at **50 mg/h**; after 30 minutes, increase by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

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

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.

Days 8 and 15:

oBINutuzumab 1000 mg IV in 250 mL NS on **Days 8 and 15.**

If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster: Start infusion at **100 mg/h** for 30 minutes; if tolerated, may escalate rate in increments of 100 mg/h every 30 minutes until rate = 400 mg/h. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle 2. Book treatment for Day 1 only.

CBC & Diff prior to Day 1 of Cycle 2
If clinically indicated: ☐ **creatinine** ☐ **ALT** ☐ **total bilirubin**
☐ **HBV viral load**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: