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

(Maintenance Cycles 7 to 18)

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 medication. RN/Pharmacist to confirm _____.

PREMEDICATIONS FOR oBINutuzumab INFUSION:

☐ If previous oBINutuzumab reaction was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before Day 1 of current cycle, 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:**

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

TREATMENT:

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 1**.

If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster: Start at **100 mg/h**. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

RETURN APPOINTMENT ORDERS

☐ Cycle 7 to 17: Return in **two** months (calculate in months, not weeks) for Doctor and Cycle _____. Book treatment for Day 1 only.

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

CBC & Diff prior to Day 1 of each cycle

If clinically indicated: ☐ **creatinine** ☐ **ALT** ☐ **total bilirubin** ☐ **HBV viral load**

☐ **Consults:**

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

☐ **Other tests:**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: