PROTOCOL CODE: LYEPOCHR (INPATIENT)

DOCTOR'S ORDERS **Ht**_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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:

Ensure patient has a central line (CVC)

☐ 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 1.0 x 10^9/L** and **platelets greater than or equal to 75 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

INPATIENT TREATMENT

- Admit to inpatient bed
- Refer to inpatient ward policies and procedures for additional orders (e.g., routine vital signs, VTE prophylaxis)

PREMEDICATIONS:

For chemotherapy portion (i.e., EPOCH portion):

predniSONE as ordered in treatment section

Select ONE of the following antiemetic regimens:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on day 1, then 80 mg PO daily on days 2 and 3 **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on day 1, then 8 mg PO daily on days 2 to 5
☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on day 1, then 8 mg PO daily on days 2 to 5

For riTUXimab:

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 **in treatment section**

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 **in treatment section**

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

Date:	**To be given:**	**Cycle #:**	**BSA:_____m^2**

SUPPORTIVE CARE MEDICATIONS

co-trimoxazole DS 1 tablet PO three times a week (Monday, Wednesday and Friday)
pantoprazole 40 mg PO daily
☐ **prochlorperazine 10 mg** PO every 6 hours prn or
☐ **metoclopramide 10 mg to 40 mg** PO every 6 hours prn
ondansetron 8mg PO/IV every 8 hours prn
dimenhyDRINATE 50mg PO/IV every 6 hours prn

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

TREATMENT #1 riTUXimab:

On Day 5 after **etoposide, DOXOrubicin, vinCRIStine**

FIRST DOSE:

riTUXimab 375 mg/m^2 x BSA = _____mg
IV in 250 to 500 mL NS. Start at 50 mg/hour.
After 1 hour, increase the rate by 50 mg/hour every 30 minutes until rate = 400 mg/hour unless toxicity occurs.

For 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.

Pharmacy to select riTUXimab brand as per Provincial Systemic Therapy Policy III-190

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

FOR ALL SUBSEQUENT riTUXimab TREATMENTS:

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

riTUXimab (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: **To be given:** **Cycle #:** **BSA:**_____m^2

TREATMENT #1: (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 (subsequent dose) 375 mg/m² 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.

For all subsequent doses, constant visual observation is not required.

Pharmacy to select riTUXimab brand as per Provincial Systemic Therapy Policy III-190

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

TREATMENT #2:

cyclophosphamide

Day 1, prior to etoposide, DOXOrubicin, vinCRIStine

- Nursing/RN to program under EPOCH-cyclophosphmide on DERS pump (refer to standard work)

☐ **mesna not needed (cyclophosphamide dose 2000 mg or less)**

cyclophosphamide - (Level* _____) _____mg/m²/day x BSA = _____mg

☐ Dose modification: _____ mg/m²/day x BSA = _____ mg/day

IV in 100 to 250 mL NS over 1 hour

OR

☐ **mesna needed (cyclophosphamide dose greater than 2000 mg)**

HR 0-1:15: **mesna** _____ **mg/m²** x BSA = _____mg

☐ Dose modification (_____%)= _____mg/m² x BSA = _____mg

IV in 100 mL NS over 15 minutes

cyclophosphamide - (Level* _____) _____mg/m²/day x BSA = _____mg

☐ Dose modification: _____ mg/m²/day x BSA = _____ mg/day

IV in 250 mL NS over 1 hour

HR 4 and 8: **mesna** _____ **mg/m²** x BSA = _____mg PO

☐ Dose modification (_____%)= _____mg/m² x BSA = _____mg

PO in 1 cup of carbonated beverage over 15 minutes (Round dose to nearest 10 mg)

OR

mesna _____ **mg/m²** x BSA = _____mg

☐ Dose modification (_____%)= _____mg/m² x BSA = _____mg

IV in 100 mL NS over 15 minutes

If cyclophosphamide dose is greater than 2000mg, dipstick urine for blood prior to **each** bag change on Days 1 to 4. If positive for blood, notify MD and send urine sample for urinalysis for verification and accurate determination of hematuria.

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

DATE: **To be given:** **Cycle #:** **BSA:_____m²**

TREATMENT #2: (continued)

predniSONE total daily dose = 120 mg/m²
i.e., 60 mg/m² X BSA = _____ PO BID with food on Day 1 to 5 (round to nearest 25 mg)

Etoposide – DOXOrubicin - vinCRIStine
Days 1 to 4

- Pharmacy to mix each daily dose of etoposide, DOXOrubicin, and vinCRIStine together in 500 mL to 1000 mL (non-DEHP) NS (use non-DEHP tubing with in-line filter)
- Nursing/RN to program under etop-DOXO-vinCRIS on DERS pump (refer to standard work)

etoposide – (Level* _____) **_____mg/m²/day** x BSA = _____mg/day
☐ Dose modification: _____ mg/m2/day x BSA = _____ mg/day

AND

DOXOrubicin - (Level* _____) **_____mg/m²/day** x BSA = _____mg/day
☐ Dose modification: _____ mg/m²/day x BSA = _____ mg/day

AND

vinCRIStine 0.4 mg/m²/day x BSA = _____mg/day (No cap)
☐ Dose modification: _____ mg/m²/day x BSA = _____ mg/day (No cap)

IV in 500 mL to 1000 mL (non-DEHP) NS over 24 hours on **Days 1 to 4** (96 hours) (use non-DEHP tubing with in-line filter)

HYDRATION:

☐ no hydration: patient to drink 3 Litres of fluids per day

☐ Hour 1:15 to 13:15: IV D51/2NS at 125 mL/h. May discontinue IV at hour 13:15 if no hematuria and able to maintain oral hydration

filgrastim to start on **_____ (Day 6)**
Complete filgrastim pre-printed order form - continue filgrastim until ANC recovery 5.0 x 10^9/L past the nadir

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

PROTOCOL CODE: LYEPOCHR (INPATIENT)

DATE: **To be given:** **Cycle #:** **BSA:_____m²**

☐ **CBC & Diff, INR, PTT** day of treatment

May proceed with intrathecal chemotherapy on Day 2 as written if within 72 hours **PTT less than or equal to the upper limit of normal, INR less than 1.5, platelets greater than or equal to 50 x 10^9/L**

May proceed with intrathecal chemotherapy on Day 5 as written if within 24 hours **PTT less than or equal to the upper limit of normal, INR less than 1.5, platelets greater than or equal to 50 x 10^9/L**

INTRATHECAL CHEMOTHERAPY: **Administration by physician only**

Patient to receive methotrexate intrathecal this cycle*

☐ Yes

☐ No

methotrexate _____**mg intrathecal** (standard dose 12 mg) on _____(Day 2)** and _____(Day 5)**

*Physician may start intrathecal chemotherapy with Cycle 1 if high risk of CNS disease
**Physician may change the days of intrathecal chemotherapy. Ensure a minimum of 48 hours between doses

Bed rest for 30 minutes after procedure in supine position.

Anticoagulant and antiplatelet therapy should be held prior to lumbar puncture as per institutional guidelines

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

MEDICATION VERIFICATION CHECKS:
Full Signatures Required

Medication/Route	Day 2	Day 5
Date (dd/mm/yyyy)		
methotrexate 12mg intrathecal	(RN)	(RN)
	(MD)	(MD)

PROTOCOL CODE: LYEPOCHR (INPATIENT)

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Book Monday admission in 3 weeks to the ward for Cycle_____ ☐ Return in 3 weeks for Doctor, prior to admission ☐ Last cycle. Return in _____ week (s)	
CBC & Diff on Day 8, 11, 15 and 18 (i.e. Mondays and Thursdays) of each Cycle (including the last Cycle) Prior to each cycle: **CBC & Diff** If receiving intrathecal methotrexate: Day 1 of each Cycle: **INR, PTT** Day 4 of each Cycle: **CBC & Diff, INR, PTT** If clinically indicated, prior to each cycle: ☐ **creatinine** ☐ **total bilirubin** ☐ **ALT** ☐ **alkaline phosphatase** ☐ **LDH** ☐ **Urinalysis** ☐ **HBV viral load** ☐ **Other tests** ☐ **Consults:**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**