PROTOCOL CODE: LYEPOCHR (OUTPATIENT)

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 #:**_____**of**_____

Date of Previous Cycle:

*****Ensure patient has central line*****

☐ 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 _____

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

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 for the LYEPOCHR protocol

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 for the LYEPOCHR protocol

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

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

PROTOCOL CODE: LYEPOCHR (OUTPATIENT)

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

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

TREATMENT:

riTUXimab:
On Day 5 after **etoposide, DOXOrubicin, vincristine**

FIRST DOSE:

riTUXimab 375 mg/m² 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):

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.

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) 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.
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.
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		

*****SEE PAGE 3 FOR CONTINUED TREATMENT ORDERS *****

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

PROTOCOL CODE: LYEPOCHR (OUTPATIENT)

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

PREDNISONE

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)

CYCLOPHOSPHAMIDE
Day 1, prior to etoposide, DOXOrubicin, vinCRIStine

☐ **cyclophosphamide dose less than or equal to 2000 mg – mesna not needed**

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

☐ **cyclophosphamide dose greater than 2000 mg - mesna needed**
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

mesna _____ mg/m² x BSA =_____mg PO(Round dose to nearest 10 mg)
☐Dose modification (_____%)= _____mg/m² x BSA = _____mg
PO in 1 cup of carbonated beverage over 15 minutes 4 hours and 8 hours after start of cyclophosphamide infusion.
Pharmacy to prepare 2 doses for outpatient use.

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 EPOCHR on CADD-Solis VIP ambulatory pump (refer to standard work)
- If total given volume on **CADD** pump is equal to volume indicated on medication label, may disconnect medication bag with volume remaining

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)

SEE PAGE 4 FOR INTRATHECAL CHEMOTHERAPY ORDERS

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

PROTOCOL CODE: LYEPOCHR (OUTPATIENT)

DATE:	**To be given:**	**Cycle #:**_____	**BSA:**_____m^2

INTRATHECAL (IT) CHEMOTHERAPY

☐ **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**

Proceed with treatment based on blood work from _____

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 and CBC, INR/PTT done within 24 hours of lumbar puncture if after day 1.

Bed rest in supine position for 30 minutes after procedure.

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 IT	(RN)	(RN)
	(MD)	(MD)

PROTOCOL CODE: LYEPOCHR (OUTPATIENT)

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor. Book chemo x 5 days. Treatment to start on a Monday

Book Filgrastim (G-CSF) SC teach prior to Day 6 of Cycle 1.

Book Nurse Telephone Follow Up every Tuesday and Friday weekly during treatment.☐ Intrathecal (IT) chemotherapy: Book IT chemo on Days 2 and 5 OR

☐ Intrathecal (IT) chemotherapy: Book IT chemo on dates _____.

☐ Last cycle. Return in _____ week (s)

☐ Last cycle. Book Nurse Telephone Follow up every Tuesday and Friday x 3 weeks.

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**

Day 8, 11, 15 and 18 (i.e. Mondays and Thursdays) of each Cycle (including the last Cycle)**: CBC & Diff**

If clinically indicated, prior to next cycle:

☐ **creatinine**
☐ **total bilirubin**
☐ **ALT**
☐ **alkaline phosphatase**
☐ **LDH**
☐ **urinalysis**
☐ **HBV viral load**
☐ Other tests:
☐ Consults:

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: