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: LYFCR

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 #: ____________

Date of Previous Cycle: ____________

☐ Delay treatment ______ week(s)
☐ CBC & Diff, Platelets, Creatinine day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Creatinine within normal limits

Note: If the patient has a serum creatinine above normal and for all patients above the age of 60 years, calculated creatinine clearance is required prior to first cycle of fludarabine, but is only required in subsequent cycles if the serum creatinine is above the normal range.

Note: If the fludarabine dose was initially reduced, and is well tolerated, the dose may be increased in subsequent cycles regardless of renal function.

Dose modification for: ☐ Hematology ☐ Other Toxicity ____________

Proceed with treatment based on blood work from ____________

TREATMENT:

Oral fludarabine 40 mg/m²/day x BSA = _________ mg PO daily for 3 consecutive days.

☐ Dose Modification: (_______ %) = _________ mg/m²/day x BSA = _________ mg

Round dose to nearest 10 mg. Do not break, chew or crush tablets. (Note: PO fludarabine, cyclophosphamide and riTUXimab to start on the same day.)

OR

IV fludarabine 25 mg/m²/day x BSA = _________ mg

☐ Dose Modification: (_______ %) = _________ mg/m²/day x BSA = _________ mg

IV in 50 to 100 mL NS over 30 minutes daily for 3 days. (Note: riTUXimab to be given within 72 hours of IV fludarabine and IV cyclophosphamide)

AND

Oral cyclophosphamide 250 mg/m²/day x BSA = _________ mg PO daily for 3 consecutive days.

☐ Dose Modification: (_______ %) = _________ mg/m²/day x BSA = _________ mg

Round dose to nearest 25 mg. (Note: PO fludarabine, cyclophosphamide and riTUXimab to start on the same day.)

OR

IV cyclophosphamide 250 mg/m²/day x BSA = _________ mg

☐ Dose Modification: (_______ %) = _________ mg/m²/day x BSA = _________ mg

IV in 50 to 100 mL NS over 30 minutes daily for 3 days. (Note: riTUXimab to be given within 72 hours of IV fludarabine and IV cyclophosphamide)

(Continued on Page 2)

DOCTOR’S SIGNATURE: ____________ SIGNATURE: ____________

UC: ____________
**Have Hypersensitivity Reaction Tray and Protocol Available**

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

For subcutaneous rituximab injection:
- diphenhydramine 50 mg PO prior to rituximab SC
- acetaminophen 650 mg to 975 mg PO prior to rituximab SC
- Other

TREATMENT: (continued)

rituximab IV or SC may be given before or after chemotherapy, on day 1 of PO fludarabine and PO cyclophosphamide OR within 72 hours after Day 1 of IV fludarabine and IV cyclophosphamide.

CYCLE #1:
- rituximab (first dose) 375 mg/m² x BSA = ___________ mg
  - IV in 250 to 500 mL NS on day 1 of PO fludarabine and PO cyclophosphamide OR within 72 hours after Day 1 of IV fludarabine and IV cyclophosphamide.

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>pharmacist Initial and Date</th>
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<tbody>
<tr>
<td>rituximab</td>
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Start at 50 mg/hour. After 1 hour, increase rate by 50 mg/hour every 30 minutes until rate = 400 mg/hour 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.

DOCTOR’S SIGNATURE:  

SIGNATURE:  

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

**TREATMENT: (continued Cycles 2-6)**

**SUBSEQUENT TREATMENTS ON CYCLES 2 TO 6:**

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

*rituximab (RITUXAN SC) 1600 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 500 mg/m² x BSA = __________ mg*

IV in 250 to 500 mL NS on day 1 of PO fludarabine and PO cyclophosphamide OR within 72 hours after Day 1 of IV fludarabine and IV cyclophosphamide.

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

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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.

**DOCTOR’S SIGNATURE:**

Date:

**SIGNATURE:**

UC:

Date:
<table>
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<tr>
<th>RETURN APPOINTMENT ORDERS</th>
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<tbody>
<tr>
<td>☐ Return in <strong>four</strong> weeks for Doctor and Cycle ___________.</td>
</tr>
<tr>
<td>☐ For PO fludarabine and cyclophosphamide, book chemo for riTUXimab treatment only.</td>
</tr>
<tr>
<td>☐ For IV fludarabine and cyclophosphamide, book chemo x <strong>3 days</strong>. Note riTUXimab to be booked within 72 hours of day 1 of IV fludarabine and cyclophosphamide.</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in ______ week(s).</td>
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</tbody>
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| CBC & Diff, Platelets, Creatinine prior to each cycle |
| Other tests: |
| Consults: |
| ☐ See general orders sheet for additional requests. |

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