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, creatinine** 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, platelets greater than or equal to 100 x 10^9/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. (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 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 100 mL NS over 20 minutes to 1 hour 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:**

Date:

****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 subcutaneous**
acetaminophen 650 mg to 975 mg PO prior to **riTUXimab subcutaneous**
☐ **Other**

TREATMENT: (continued)

riTUXimab IV or subcutaneous 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/m^2 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

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

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:**

Date:

****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 subcut (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/m^2 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

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

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:	**SIGNATURE:** **UC:**

Date:	
RETURN APPOINTMENT ORDERS	
☐ Return in **four** weeks for Doctor and Cycle _____. ☐ For PO fludarabine and cyclophosphamide, book chemo for riTUXimab treatment only. ☐ For IV fludarabine amd cyclophosphamide, book chemo x **3 days.** Note riTUXimab to be booked within 72 hours of day 1 of IV fludarabine and cyclophosphamide. ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, creatinine prior to each cycle If clinically indicated: ☐ **ALT** ☐ **HBV viral load** every 3 months ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**