PROTOCOL CODE: LYFLUDR

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, creatinine** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 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:

☐ **Standard Dose:**
Oral fludarabine 40 mg/m^2/day x BSA = _____ mg PO daily for **5 consecutive days**.
Round dose to nearest 10 mg. (Note: PO fludarabine and riTUXimab to start on the same day.

OR

☐ **Dose Modification Required:**
Oral fludarabine 32 mg/m^2/day x BSA = _____mg PO daily for **3 consecutive days**.
Round dose to nearest 10 mg. (Note: PO fludarabine and riTUXimab to start on the same day)

OR

☐ **Standard Dose:**
IV fludarabine 25 mg/m^2/day x BSA = _____ mg
IV in 100 mL NS over 30 minutes daily for **5 days.** (Note: riTUXimab to be given within 72 hours of IV fludarabine)

OR

☐ **Dose Modification Required:**
IV fludarabine 20 mg/m^2/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)

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

DOCTOR'S ORDERS

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, but within 72 hours after Day 1 of fludarabine

TREATMENT #1:

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS within 72 hours after Day 1 of fludarabine.

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/h. After 1 hour, increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h 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.

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

DOCTOR'S ORDERS

Date:

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

TREATMENT: (Continued)

FOR ALL SUBSEQUENT TREATMENTS:

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

riTUXimab subcut (RITUXAN SC) 1400 mg (fixed dose in 11.7 mL) subcutaneously into abdomen over 5 minutes within 72 hours after Day 1 of fludarabine. Observe for 15 minutes after administration.

NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.

☐ 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 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS within 72 hours after Day 1 of fludarabine.

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.

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.

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

Date:	
RETURN APPOINTMENT ORDERS	
☐ Return in **four** weeks for Doctor and Cycle _____. ☐ For PO fludarabine, book chemo for riTUXimab treatment only. ☐ For IV fludarabine, book chemo x ☐ **5 days** OR ☐ **3 days** (*select one*). (Match to dose duration above) Note riTUXimab to be booked within 72 hours of IV Fludarabine. ☐ 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:**