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: LYIDELAR

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:

☐ 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 0.5 x 10^9/L, platelets greater than or equal to 25, ALT/AST less than or equal to 5 x ULN, bilirubin less than or equal to 3 x ULN**

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

Proceed with treatment based on blood work from _____

****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**

TREATMENT:

Physician to ensure antibiotic prophylaxis for PCP/PJP (e.g., cotrimoxazole 1 single-strength tab daily) is given throughout idelalisib treatment and for a period of 2 to 6 months after discontinuation.

Counsel patient to obtain supply of loperamide and take 2 mg PO at first onset of diarrhea and q2h while awake and q4h during the night until diarrhea free x 12 hours

For Cycle 1 ONLY

idelalisib ☐ **150 mg** or ☐ **100 mg** (*select one*) PO BID continuously
Mitte: 30 days (dispense in original container)

(Continued on page 2)

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

DOCTOR'S ORDERS

DATE:

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

TREATMENT continued:

For Cycle 1 only (continued):

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS on Day 1. 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.

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		

For the first dose, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. 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. Vital signs are not required, unless symptomatic.

Cycle 2, 3, 4, 5, 6, 7 and 8

idelalisib ☐ **150 mg** or ☐ **100 mg** (*select one*) PO BID continuously
Mitte: 30 days (dispense in original container)

riTUXimab for Cycle 2 and 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) 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.

See page 3

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

DOCTOR'S ORDERS

DATE:

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

TREATMENT (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 500 mg/m² x BSA = _____ mg
IV in 250 to 500 mL NS

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.

Cycle 9 and beyond

idelalisib ☐ **150 mg** or ☐ **100 mg** (*select one*) PO BID continuously
Mitte: ☐ 30 days or ☐ 60 days or ☐ 90 days (dispense in original container)

RETURN APPOINTMENT ORDERS

☐ Cycle 1 to 8: Return in **four** weeks for Doctor and Cycle _____. Book chemo on Day 1
☐ Cycle 9 and beyond: Return in _____ weeks (maximum 12 weeks) for Doctor
☐ Last Cycle. Return in _____ week(s).

Cycles 1-3:
CBC & Diff, total bilirubin, ALT, CMV-DNA by PCR every two weeks

Cycles 4-6:
CBC & Diff, total bilirubin, ALT, CMV-DNA by PCR monthly

Cycle 7 and subsequent cycles:
CBC & Diff, total bilirubin, ALT, CMV-DNA by PCR monthly **OR** ☐ every 3 months, as clinically indicated

If clinically indicated:
☐ **HBV viral load**
☐ **Consults:**
☐ **Other tests:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: