**PROTOCOL CODE: LYIVACR**

PPO FOR THE TREATMENT OF BURKITT LYMPHOMA AND LEUKEMIA

**LYIVAC** *(Magrath B) + R (ritUXimab)*

*[To be used after LYCODOX-M (Magrath A) + R]*

<table>
<thead>
<tr>
<th>DAY</th>
<th>DATE</th>
<th>CHEMOTHERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>_______</td>
<td>Start signature sheet and prednisoLONE 0.12% eye drops pre cytarabine</td>
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<tr>
<td></td>
<td></td>
<td>cytarabine 2000 mg/m² IV q12h at 1000h and 2200h</td>
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<td></td>
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<td>ifosfamide 1500 mg/m² IV at 1200h</td>
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<td>4</td>
<td>_______</td>
<td>ritUXimab 375 mg/m² IV (or 1400 mg SC if IV tolerated)</td>
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<tr>
<td>6</td>
<td>_______</td>
<td>methotrexate 12 mg Intrathecal, if platelets greater than 50 x 10⁹/L</td>
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<tr>
<td>&gt; 18</td>
<td>_______</td>
<td>methotrexate 12 mg Intrathecal, after day 18, once platelets greater than 50 x 10⁹/L</td>
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</tbody>
</table>

**NOTES:**

1. Continue prednisoLONE 0.12% eye drops until 48 hours after last dose of cytarabine

2. All chemotherapy doses are calculated using actual body weight

3. One staff physician signature is required. Orders written by residents and fellows MUST be cosigned.
**PROTOCOL CODE: LYIVACR**

### PROTOCOL CODE: LYIVAC (MAGRATH B) + R (ritUXimab) CHEMOTHERAPY REGIMEN

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

Date/Time:

Cycle #:

- Admit to inpatient bed
  - **GENERAL CONSENT SIGNED**

**LABORATORY:**

**Before each treatment:** CBC & diff, platelets, creatinine, sodium, potassium, ALT, bilirubin, alkaline phosphatase, LDH

**Daily q am during treatment:** CBC & diff, platelets, creatinine, sodium, potassium, ALT

**PREMEDICATIONS:**

For Day 1 to 5 IVAC portion:
- ondansetron 8 mg PO/IV pre-chemotherapy, then every 12 hours until day 5
- dexamethasone 12 mg PO pre-chemotherapy daily until day 5

For Day 4 ritUXimab portion:
- See ritUXimab pre-printed order

Complete G-CSF (filgrastim) pre-printed order form

Complete Febrile Neutropenia pre-printed order form

**NOTE:** One staff Physician signature is required. Orders written by residents and fellows **MUST** be cosigned.

<table>
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<th>RN:</th>
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<tr>
<td>Doctor 2 Signature:</td>
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### LYIVAC (MAGRATH B) + R (riTUXimab) CHEMOTHERAPY REGIMEN

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**Date/Time:**

#### CHEMOTHERAPY:

On _______ ______ (day 1) at 0600h, start IV hydration with 2/3D5W1/3NS + ______ mEq potassium chloride/L + ______ g magnesium sulfate/L at 125 mL/hr (3000 mL/day).

On _______ ______ (day 1) at 1000h, give cytarabine ________mg (2000 mg/m²) in 100 mL NS IV over 2 hours. Repeat q12h for a total of 4 doses ( _____________ , ________________ ).

prednisolONE 0.12% ophthalmic drops 2 drops in each eye q4h, starting immediately before first dose of cytarabine and continuing until 48 hours after the last dose of cytarabine.

Start signature screening sheet for cytarabine cerebellar toxicity.

On _______ ______ (day 1) at 1200h, give ifosfamide ________mg (1500 mg/m²) in 500 mL NS IV over 2 hours. Repeat daily for a total of 5 days ( _____________ , _______________ , ______________ , ______________ , ______________ ).

On _______ ______ (day 1), 30 minutes prior to ifosfamide dose, give MESNA ________mg (375 mg/m²) in 100 mL D5W IV over 15 minutes, then repeat at 3, 6 and 9 hours after ifosfamide dose (i.e., 4 doses/day for a total of MESNA 1500 mg/m²/day). Repeat daily for a total of 5 days ( _____________ , _______________ , ______________ , ______________ , ______________ ).

On _______ ______ (day 1) at 1400h, give etoposide ________mg (60 mg/m²) in 250 to 500 mL (non-DEHP bag) NS IV over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter). Repeat daily for a total of 5 days ( _____________ , _______________ , ______________ , ______________ , ______________ ).

**NOTE:** One staff Physician signature is required. Orders written by residents and fellows MUST be cosigned.

Doctor 1 Signature:                                                   Doctor 2 Signature:
LYIVAC (MAGRATH B) + R (riTUXImab) CHEMOTHERAPY REGIMEN

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**CHEMOTHERAPY (Cont'd):**

On _____________ (day 4), give riTUXImab 375mg/m² – Complete attached LYIVAC + R – riTUXImab Treatment pre-printed order form.

On _____________ (day 6) at ________ h, have *methotrexate* 12 mg at bedside for intrathecal instillation, if platelet recovery greater than 50 x 10⁹/L – Complete attached LYIVAC-IT pre-printed order form.

*Methotrexate* 12 mg also to be given via intrathecal instillation after day 18, once platelet count is greater than 50 x 10⁹/L – Complete attached LYIVAC-IT pre-printed order form.

A total of 8 doses of intrathecal chemotherapy should be given during the course of all treatments, 2 doses per cycle of chemotherapy, then the concluding doses, 1 dose per week, after all other treatments are complete.

**SUPPORTIVE CARE:**

On _______________ (day 7), start *fluconazole* 400 mg PO DAILY

For HSV seropositive: On _______________ (day 7), start valACYclovir 500 mg po daily OR acyclovir ________ mg (5 mg/kg) IV q12h. Please use the oral route, if the patient can swallow.

On _______________ (day 7), start filgrastim as per pre-printed order, and continue until ANC greater than 1. Complete G-CSF (filgrastim) pre-printed order form.

**NOTE:** One staff Physician signature is required. Orders written by residents and fellows MUST be cosigned.

Doctor 1 Signature:                                                   Doctor 2 Signature:
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.

**DOCTOR'S ORDERS**

<table>
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<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**DATE:**

Date of Previous Cycle:

- □ Delay treatment _________ week(s).
- □ CBC & Diff and Platelets on the day of treatment.
  Proceed with treatment based on blood work from _________.

**PREMEDICATIONS:**

**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:

  **Have Hypersensitivity Tray and Protocol Available**

**TREATMENT: (Continued)**

On ____________ (day 4):

**ADJUNCTIVE CHEMOTHERAPY,** use Actual BSA

riTUXimab (first dose) 375 mg/m² x BSA = _________ mg

IV in 250 to 500 mL NS over 3 to 8 hours (may divide dose equally into 2 x 250 mL NS).

**TREATMENT #1:**

Start at 50 mg/h. After 60 minutes, increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h 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.

**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 (subsequent dose) 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.

**NOTE:** One staff Physician signature is required. Orders written by residents and fellows MUST be cosigned.

Doctor 1 Signature:       Doctor 2 Signature:
### 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:

  \[
  \text{riTUXimab (subsequent dose) } 375 \text{ mg/m}^2 \times \text{BSA} = \ \ \ \ \ \ \ \ \ \ \ \text{mg}
  \]

  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.

### NOTE: One staff Physician signature is required. Orders written by residents and fellows MUST be cosigned.

**Doctor 1 Signature:**

**Doctor 2 Signature:**

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**INTRATHecal (IT) CHEMOTHERAPy: (BY PHYSICIAN ONLY)**

- **methotrexate 12 mg IT (intrathecal) qs to 6 mL with preservative-free NS on ___________ (day 6), if platelets greater than 50 x 10⁹/L.**

- **methotrexate 12 mg IT (intrathecal) qs to 6 mL with preservative-free NS on ___________ (after day 18), if platelets greater than 50 x 10⁹/L.**

**DO NOT GIVE MORE THAN ONE IT (intrathecal) MEDICATION at any given time.**

Bed rest for 30 minutes after procedure in prone (abdomen down) position.

- See General order sheet for additional requests.

**DOCTOR’S SIGNATURE:**

(ONE SIGNATURE REQUIRED)

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**MEDICATION VERIFICATION CHECKS**

Full Signatures Required

<table>
<thead>
<tr>
<th>Medication/Route</th>
<th>Day 6</th>
<th>Day __________ (after day 18)</th>
</tr>
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<tbody>
<tr>
<td>methotrexate 12mg IT</td>
<td>(RN)</td>
<td>(RN)</td>
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<td>(MD)</td>
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