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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: LYOBCHLOR

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** day of treatment

May proceed with doses as written if within 96 hours Day 1 **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 80 x 10^9/L**

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

Proceed with treatment based on blood work from _____

TREATMENT:

Cycles 1 to 6:

chlorambucil 0.5 mg/kg or ☐ _____ mg/kg = _____ mg (**Maximum dose = 0.8 mg/kg every 2 weeks**) PO for one dose on **Days 1** and **15.**

Round dose to the nearest 2 mg.

Mitte: 28 days

PREMEDICATIONS for oBINutuzumab Infusion:

Patient to take own supply of oral medications. RN/Pharmacist to confirm _____.

If ordered, ensure patient has taken steroid the day(s) prior to infusion.

Cycle 1: Days 1 and 2:

60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** PO

Cycle 1: Days 8 and 15:

☐ If reaction to previous oBINutuzumab was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before Cycle 1, then 60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO **and diphenhydrAMINE 50 mg** PO

Cycles 2 to 6:

☐ If reaction to previous oBINutuzumab was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before Day 1 of current cycle, then 60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** PO

TREATMENT Continued on Page 2

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

Date:

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

TREATMENT, continued

☐ **Cycle 1**

Day 1:

oBINutuzumab 100 mg IV in 100 mL NS on **Day 1**.
Administer over 4 hours at **25 mg/h**. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

Day 2:

oBINutuzumab 900 mg IV in 250 mL NS on **Day 2**.
Start at **50 mg/h**; after 30 minutes, increase by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

Cycle 1 Days 1 and 2: constant visual observation during dose increases and for 30 minutes after infusion completed. Vital signs not required unless symptomatic.

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.

Days 8 and 15:

oBINutuzumab 1000 mg IV in 250 mL NS on **Days 8 and 15**.
If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate was 100 mg/h or faster: Start at **100 mg/h**. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

☐ **Cycles 2 to 6:**

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 1**.
If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster: Start at **100 mg/h**. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

RETURN APPOINTMENT ORDERS

For Cycle 1, book treatment on Days 1, 2, 8 and 15. For Cycles 2 to 6, book treatment on Day 1 only. ☐ Return in **four** weeks for Doctor and Cycle _____. ☐ Last Cycle. Return in _____ week(s)	
CBC & Diff prior to each cycle If clinically indicated: ☐ **phosphate** ☐ **potassium** ☐ **calcium** ☐ **uric acid** ☐ **ALT** ☐ **HBV viral load** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**