PROTOCOL CODE: LYRICE

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 72 hours **ANC greater than or equal to 0.8 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than 60 mL/min**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
ondansetron 8 mg PO 30 to 60 minutes prior to treatment on Days 1 to 3
dexamethasone 12 mg PO 30 to 60 minutes prior to treatment on Days 1 to 3
☐ **aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1; then **80 mg** PO daily on Day 2 and 3
If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment
☐ **hydrocortisone 100 mg** IV prior to etoposide
☐ **diphenhydrAMINE 50 mg** IV prior to etoposide
☐ **Other:**

Dipstick urine for blood prior to **each** ifosfamide treatment on Days 1, 2, 3 and if positive for blood, notify MD and send urine sample for urinalysis for verification and accurate determination of hematuria.

CHEMOTHERAPY:
ifosfamide 1667 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 500 mL NS over 2 hours (y-site to mesna)* daily on **Day 1,2,3** (total dose per cycle = 5000 mg/m^2)

mesna 1667 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 500 mL NS over 2 hours (y-site to ifosfamide)* daily on **Day 1,2,3** (total dose per cycle = 5000 mg/m^2)
*ifosfamide and mesna infused concurrently via Y-site connector placed immediately before injection site

mesna 2000 mg PO 2h and 4h after completion of ifosfamide on **Day 1,2,3**
To be taken at home in 1 cup of carbonated beverage over 15 minutes. Pharmacy to prepare 2 doses daily for outpatient use.

CARBOplatin AUC 5 x (GFR + 25) = _____ mg
☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 1 hour on **Day 1** ONLY. (Maximum dose = 800 mg)

etoposide 100 mg/m^2/day x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg
IV in 250 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes daily on **Day 1,2,3** (use non-DEHP tubing with 0.2 micron in-line filter)
(total dose per cycle = 300 mg/m^2)

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

Date:

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**

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

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

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		

TREATMENT #1:

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.

If flushing, dyspnea, rigors, rash, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.

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 of Day 1 of ICE. Observe for 15 minutes after administration.

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

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

Date:

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

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, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.

For all subsequent doses, constant visual observation is not required.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____ Book chemo for 3 days

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, total bilirubin, creatinine, LDH prior to each cycle

If clinically indicated:

☐ **HBV viral load** every 3 months

☐ **ALT**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: