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: LYRITUX

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
Proceed with treatment based on blood work from _____

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:**

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

TREATMENT:

WEEK 1:
riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS over 3-8 hours (may divide dose equally into 2 x 250 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		

Start infusion at 50 mg/h, after 1 hour, increase by 50 mg q 30 minutes to maximum 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 acute discomfort occurs, stop infusion and page physician.

Patient may leave if stable 30 minutes after infusion completed.

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

DATE:

TREATMENT: (Continued)

SUBSEQUENT TREATMENTS ON WEEKS 2, 3 AND 4:

☐ 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.
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 over 3-8 hours.

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 infusion at 100 mg/h, after 30 minutes, increase by 100 mg/h q 30 minutes to maximum 400 mg/h.

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

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.

Patient may leave if stable 30 minutes after infusion completed.

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

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in _____ week(s) for Doctor. Book chemo weekly for a total of up to 4 treatments (note: maximum of 4 treatments in total). ☐ Treatment finished. Return in _____ week (s).	
CBC & Diff prior to treatment 1 and 4. 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:**