PROTOCOL CODE: LYCVPR

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 and Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

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 prior to treatment

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO prior to treatment

☐ **Other:**

CHEMOTHERAPY:

predniSONE 100 mg PO daily in AM on days 1 to 5.

vinCRIStine 1.4 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 50 mL NS over 15 mins.

cyclophosphamide 1000 mg/m^2 x BSA = _____mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour.

RITUXIMAB WITHIN 72 HOURS OF CVP

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

predniSONE as ordered for the LYCVPR protocol

For subcutaneous riTUXimab injection:

diphenhydrAMINE 50 mg PO prior to **riTUXimab subcutaneous**

acetaminophen 650 mg to 975 mg PO prior to **riTUXimab subcutaneous**

predniSONE as ordered for the LYCVPR protocol

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: LYCVPR

Date:

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

TREATMENT: (continued)TREATMENT #1:

riTUXimab IV or subcutaneous may be given before or after chemotherapy, but within 72 hours of CVP

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg

IV in 250 to 500 mL NS within 72 hours after day 1 of CVP.

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 at 50 mg/hour. After 1 hour, increase rate by 50 mg/hr 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.

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.
Observe for 15 minutes after administration.

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

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

(Continued on page 3)

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

PROTOCOL CODE: LYCVPR

Date:

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

TREATMENT: (continued for Subsequent Treatments):

☐ 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/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.

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.

RETURN APPOINTMENT ORDERS

☐ Return in ☐ **three** or ☐ **four** weeks (select one) for Doctor and Cycle _____ ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, platelets prior to each cycle ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**