

PROTOCOL CODE: LYLENR (Cycle 1)

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Patient RevAid ID: _____

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:		
Risk Category: <input type="checkbox"/> Female of Childbearing Potential (FCBP)		
Risk Category: <input type="checkbox"/> Male or Female of non - Childbearing Potential (NCBP)		
<input type="checkbox"/> Delay treatment _____ week(s)		
<input type="checkbox"/> CBC & Diff day of treatment		
Proceed with doses as written if within 48 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 50 x 10⁹/L and eGFR or creatinine clearance as per protocol		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal dysfunction <input type="checkbox"/> Other toxicity: _____		
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		
<input type="checkbox"/> Other:		
<p>LENALIDOMIDE</p> <p>One cycle = 28 days</p> <p><input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days</p> <p><input type="checkbox"/> lenalidomide* _____ mg PO _____</p> <p>(*available as 20 mg, 15 mg, 10 mg, 5 mg and 2.5 mg capsules)</p> <p>*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based</p> <p><input type="checkbox"/> FCBP dispense 21 capsules (1 cycle)</p> <p><input type="checkbox"/> For Male and Female NCBP:</p> <p>Mitte: _____ capsules or _____ cycles. Maximum 63 capsules (3 cycles).</p> <p>Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed</p> <p>Physician to ensure DVT prophylaxis in place: <input type="checkbox"/> ASA or <input type="checkbox"/> Warfarin or <input type="checkbox"/> low molecular weight heparin or <input type="checkbox"/> direct oral anticoagulant or <input type="checkbox"/> none (select one)</p> <ul style="list-style-type: none"> • Per physician's clinical judgement, physician to ensure prophylaxis with vaIACYclovir 500 mg PO daily <p>Special instructions: _____</p>	<p>Pharmacy Use for Lenalidomide dispensing:</p> <p>Part Fill # 1 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p> <p>Part Fill # 2 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p> <p>Part Fill # 3 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:	
Physician Revaid ID: _____	UC:	

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DATE:

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

TREATMENT:

DAY 1:

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

IV in 250 to 500 mL NS on **Day 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.

Pharmacist 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		

SUBSEQUENT WEEKLY TREATMENTS ON DAYS 8, 15 AND 22:

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/m² x BSA = _____ 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.

Pharmacist 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		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
<p>For Cycle 1 book treatment on Days 1, 8, 15 and 22</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle 2. Book treatment on Day 1 only.</p>	
<p>CBC & Diff, creatinine, ALT, total bilirubin, LDH prior to Day 1 of each cycle</p> <p>Cycle 1 weekly prior to Days 8, 15 and 22: CBC & Diff</p> <p>TSH every three months (i.e. prior to cycles 4, 7, 10, etc)</p> <p>If clinically indicated:</p> <p><input type="checkbox"/> Quantitative beta-hCG blood test for FCBP 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1</p> <p><input type="checkbox"/> Quantitative beta-hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle</p> <p><input type="checkbox"/> HBV viral load every 3 months</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: