Provincial Health Services Authority

PROTOCOL CODE: LYPOLARCHP

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 1 of treatment

May proceed with doses as written, if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L** and **platelets greater than or equal to 50 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* PO prior to treatment
and **select** ONE of the following:

☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

☐ **hydrocortisone 100 mg** IV prior to etoposide
☐ **diphenhydrAMINE 50 mg** IV prior to etoposide
☐ **Other**

For polatuzumab vedotin:
☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to polatuzumab vedotin infusion
☐ **acetaminophen 650 mg to 975 mg** PO 30 minutes prior to polatuzumab vedotin infusion

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 **in treatment section**

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 **in treatment section**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:

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

TREATMENT:

CYCLE #1:

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

DOXOrubicin 50 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push on **Day 1.**

cyclophosphamide 750 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour on **Day 1.**

polatuzumab vedotin 1.8 mg/kg x _____ kg = _____mg
☐ Dose Modification: _____mg/kg x _____ kg = _____ mg
IV in 50 to 250 mL NS over 1 hour and 30 minutes (with 0.2 micron in-line filter) on **Day 1**
Vital signs immediately before the start of infusion, every 30 minutes during the infusion, at the end of infusion and every 30 minutes during the 90-minute observation period following completion of infusion.

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS on **Day 2** whenever possible but no later than 72 hours after Day 1.

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/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.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

Date:

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

TREATMENT continued:

Cycle # _____ (Cycles 2 to 6)

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

DOXOrubicin 50 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push on **Day 1.**

cyclophosphamide 750 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour on **Day 1.**

polatuzumab vedotin 1.8 mg/kg x _____ kg = _____mg
☐ Dose Modification: _____mg/kg x _____ kg = _____ mg
IV in 50 to 250 mL NS over 30 minutes (with 0.2 micron in-line filter) on **Day 1**
Vital signs immediately before the start of infusion, at the end of infusion and when needed. Observe patient for 30 minutes following completion of infusion.

riTUXimab SUBSEQUENT TREATMENTS:

riTUXimab IV or subcutaneous may be given before or after chemotherapy, but within 72 hours after Day 1

☐ 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 on **Day 1** whenever possible but no later than 72 hours after Day 1.
Observe for 15 minutes after administration.
NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.

*****continued on page 4*****

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

Date:

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

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/m² x BSA = _____ mg
IV in 250 to 500 mL NS on **Day 1** whenever possible but no later than 72 hours after Day 1.

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. (total infusion time = 1 hour 30 min)
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.

<u>If cardiac dysfunction</u>:
Omit **DOXOrubicin**.
Give **etoposide 50 mg/m²** x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 45 minutes on **Day 1** (Use non-DEHP tubing with in-line filter), AND

etoposide 100 mg/m² x BSA x (_____ %) = _____mg PO on **Days 2 and 3** (Round dose to nearest 50 mg)

<u>If total bilirubin greater than 85 micromol/L</u>:
Omit **DOXOrubicin**.
Change **cyclophosphamide** to **1100 mg/m²** x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour on **Day 1.**

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

Date:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks or _____ weeks for Doctor and Cycle_____. Book chemo for Cycle 1 on Days 1 and 2. Book chemo for Cycles 2 to 6 on Days 1. Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day 7 ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, total bilirubin, ALT prior to Day 1 of each cycle If clinically indicated: ☐ **LDH** ☐ **alkaline phosphatase** ☐ **creatinine** ☐ **HBV viral load** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**