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: LYBRENTUX

DOCTOR'S ORDERS

Wt_____kg

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 1 of treatment

May proceed with doses as written, if within 96 hours **ANC greater than or equal to 0.6 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: Not routinely necessary.
If required after Cycle 1 due to prior infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to brentuximab vedotin

☐ **acetaminophen 650 mg to 975 mg** PO 30 minutes prior to brentuximab vedotin

☐ **Other**

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

TREATMENT:

brentuximab vedotin 1.8 mg/kg x weight (kg) = _____ mg (maximum dose 180 mg)

☐ Dose Modification: _____% = _____ mg/kg x weight (kg) = _____ mg
IV in 100 mL NS over 30 minutes on **Day 1.**

NOTE: The dose for patients weighing greater than 100 kg should be calculated based on a weight of 100 kg.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. Book chemo on Day 1. ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, platelets prior to Day 1 of each cycle If clinically indicated: ☐ creatinine ☐ ALT ☐ total bilirubin ☐ **HBV viral load every 3 months** ☐ **HBsAg every 3 months** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE	**SIGNATURE:** **UC:**