PROTOCOL CODE: LYPOLABR

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 1 of treatment

Day 1: may proceed with doses as written, if within 72 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 _____.

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**

For polatuzumab vedotin:

☐ **diphenhydrAMINE 50 mg** PO prior to infusion

☐ **acetaminophen 650 mg to 975 mg** PO prior to infusion

Cycle 1:

DAY 2 and DAY 3

ondansetron 8 mg PO prior to treatment.

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

Cycles 2 to 6:

DAY 1 and DAY 2

ondansetron 8 mg PO prior to treatment.

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

☐ **Other**

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

DATE:

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

TREATMENT:

CYCLE #1:

riTUXimab (first dose) 375 mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS on **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.

polatuzumab vedotin 1.8 mg/kg x _____ kg = _____mg

☐ Dose Modification: 1.4 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 2**

Vitals monitoring:

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.

Bendamustine may be infused during the polatuzumab vedotin observation period. If flushing, dyspnea, rash, new pruritis, vomiting, or any other new acute discomfort occurs, stop infusion and page physician.

bendamustine 90 mg/m^2 x BSA = _____ mg

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

IV in 250 to 500 mL NS over 1 hour on **Day 2 and Day 3.**

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

Date:

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

TREATMENT continued:

Cycle # _____ (cycles 2 to 6)

polatuzumab vedotin 1.8 mg/kg x _____ kg = _____mg

☐ Dose Modification: 1.4 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**

Vitals monitoring:

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.

Bendamustine may be infused during the polatuzumab vedotin observation period. If flushing, dyspnea, rash, new pruritis, vomiting, or any other new acute discomfort occurs, stop infusion and page physician.

bendamustine 90 mg/m^2 x BSA = _____ mg

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

IV in 250 to 500 mL NS over 1 hour on **Day 1 and Day 2.**

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 on **Day 1 or 2** whenever possible, but not later than 72 hours after Day 1 of polatuzumab vedotin

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 on **Day 1 or 2** whenever possible, but not later than 72 hours after Day 1 of polatuzumab vedotin
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.

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, 2 and 3. Book chemo for Cycles 2 to 6 on Days 1 and 2. Note: riTUXimab to be booked within 72 hours of polatuzumab vedotin. ☐ Last Cycle. Return in _____ week(s).	
CBC & differential, platelets, creatinine, total bilirubin, ALT, alkaline phosphatase prior to Day 1 of each cycle If clinically indicated: ☐ sodium, potassium ☐ calcium ☐ albumin ☐ phosphate ☐ uric acid ☐ direct bilirubin ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**