PROTOCOL CODE: LYRITZ

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 #:**

☐ **CBC & Diff, Platelets** day of treatment
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
diphenhydrAMINE 50 mg PO prior to treatment and 4 hours after beginning riTUXimab.
acetaminophen 650-975 mg PO prior to treatment and 4 hours after beginning riTUXimab.
☐ **Other:**

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

TREATMENT (to be delivered at BC Cancer Vancouver Centre only)

DAY 1
riTUXimab (first dose) 250 mg/m^2 x BSA = _____ mg IV in 250 mL NS over 2 to 8 hours 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 infusion at 50 mg/h, after 60 minutes, increase by 50 mg/h every 30 minutes to maximum 400 mg/h unless toxicity occurs.
☐ Start infusion at 25 mg/h (strongly advised for patients with detectable circulating lymphoma cells)
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.
Patient may leave if stable 30 minutes after infusion completed.

Second riTUXimab dose given on ONE of ☐ DAY 7 or ☐ DAY 8 or ☐ DAY 9 (select one)
riTUXimab (subsequent dose) 250 mg/m^2 x BSA = _____ mg IV in 250 mL NS over 2 to 8 hours on ONE of ☐ day 7 or ☐ day 8 or ☐ day 9 **(select one)**

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		

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.
If no adverse event seen with previous infusion, start infusion at 100 mg/h. Increase rate by 100 mg/h every 30 minutes to maximum 400 mg/h unless toxicity occurs.
Saline lock IV for transfer to Nuclear Medicine Dept.

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. After recovery of symptoms, restart riTUXimab infusion at one infusion rate below the rate at which the reaction occurred and continue with escalation of infusion rates on the appropriate schedule above. If the infusion must be stopped a second time, restart after clearance of symptoms, at one infusion rate lower and continue at that rate without further escalation.

DOCTOR'S SIGNATURE:	SIGNATURE: UC:

Date:	
RETURN APPOINTMENT ORDERS	
☐ Book chemo for day 1 and for the second riTUXimab dose on ONE of day 7 or day 8 or day 9. (Note: the second riTUXimab dose to be coordinated with Nuclear Medicine) ☐ RTC _____ weeks.	
CBC and Diff, Platelets, Creatinine, Bilirubin, ALT prior to day 1. Post second riTUXimab dose i.e., post day 7 or day 8 or day 9: **CBC and Diff, Platelets** weekly x 12 weeks ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: