



Provincial Health Services Authority

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: LYRICE

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:					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 72 hours ANC greater than or equal to 0.8 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 60 mL/min Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO 30 to 60 minutes prior to treatment on Days 1 to 3 dexamethasone 12 mg PO 30 to 60 minutes prior to treatment on Days 1 to 3 <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to treatment on Day 1; then 80 mg PO daily on Day 2 and 3 If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to treatment <input type="checkbox"/> hydrocortisone 100 mg IV prior to etoposide <input type="checkbox"/> diphenhydrAMINE 50 mg IV prior to etoposide <input type="checkbox"/> Other:					
Dipstick urine for blood prior to each ifosfamide treatment on days 1, 2, 3 and if positive for blood, notify MD and send urine sample for urinalysis for verification and accurate determination of hematuria.					
CHEMOTHERAPY: ifosfamide 1667 mg/m ² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 500 mL NS over 2 hours (y-site to mesna)* daily on day 1,2,3 (total dose per cycle = 5000 mg/m ²) mesna 1667 mg/m ² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 500 mL NS over 2 hours (y-site to ifosfamide)* daily on day 1,2,3 (total dose per cycle = 5000 mg/m ²) *ifosfamide and mesna infused concurrently via Y-site connector placed immediately before injection site mesna 2000 mg PO 2h and 4h after completion of ifosfamide on day 1,2,3 To be taken at home in 1 cup of carbonated beverage over 15 minutes. Pharmacy to prepare 2 doses daily for outpatient use.					
CARBOplatin AUC 5 x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 1 hour on day 1 ONLY . (Maximum dose = 800 mg)					
etoposide 100 mg/m ² /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 250 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes daily on day 1,2,3 (use non-DEHP tubing with 0.2 micron in-line filter) (total dose per cycle = 300 mg/m ²)					
EMERGENCY DRUGS FOR MANAGEMENT OF ETOPOSIDE TOXICITY: hydrocortisone 100 mg IV prn / diphenhydrAMINE 50 mg IV prn					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

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Date:							
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.							
<p>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</p> <p>For subcutaneous riTUXimab injection: diphenhydramine 50 mg PO prior to riTUXimab subcutaneous acetaminophen 650 mg to 975 mg PO prior to riTUXimab subcutaneous</p>							
Have Hypersensitivity Reaction Tray and Protocol Available							
<p>riTUXimab (first dose) 375 mg/m² x BSA = _____ mg IV in 250 to 500 mL NS within 72 hours of day 1 of ICE.</p> <p>Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Drug</th> <th style="width: 40%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td>riTUXimab</td> <td></td> <td></td> </tr> </tbody> </table>		Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	riTUXimab		
Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date					
riTUXimab							
<p>TREATMENT #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. If flushing, dyspnea, rigors, rash, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.</p> <p>FOR ALL SUBSEQUENT TREATMENTS: <input type="checkbox"/> Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:</p> <p>riTUXimab subcut (RITUXAN SC) 1400 mg (fixed dose in 11.7 mL) subcutaneously into abdomen over 5 minutes within 72 hours of day 1 of ICE. Observe for 15 minutes after administration.</p> <p>NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.</p>							
DOCTOR'S SIGNATURE:	SIGNATURE:						
	UC:						



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Date:

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 within 72 hours of day 1 of ICE.

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.

If flushing, dyspnea, rigors, rash, new pruritus, vomiting, chest pain or any other new acute discomfort occurs, stop infusion and page physician.

For all subsequent doses, constant visual observation is not required.

RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _____ Book chemo for 3 days
- Last Cycle. Return in _____ week(s).

CBC and Diff, Platelets, Total Bilirubin, Creatinine, LDH prior to each cycle

- Other tests:**
- Consults:**
- See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: