



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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

### PROTOCOL CODE: LYBV

<b>DOCTOR'S ORDERS</b>		Wt _____ kg
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>
Date of Previous Cycle:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff and platelets</b> day 1 of treatment		
Day 1: may proceed with doses as written, if within 96 hours <b>ANC greater than or equal to <math>0.6 \times 10^9/L</math></b> and <b>Platelets greater than or equal to <math>50 \times 10^9/L</math></b>		
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____		
<b>Proceed with treatment based on blood work from</b> _____		
<b>PREMEDICATIONS:</b> Not routinely necessary.		
If required after Cycle 1 due to prior infusion reaction:		
<input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to brentuximab vedotin		
<input type="checkbox"/> <b>acetaminophen 650 mg to 975 mg</b> PO 30 minutes prior to brentuximab vedotin		
<input type="checkbox"/> <b>Other</b>		
<b>** Have Hypersensitivity Reaction Tray and Protocol Available**</b>		
<b>TREATMENT:</b>		
<b>brentuximab vedotin 1.8 mg/kg x weight (kg) =</b> _____ mg (maximum dose 180 mg)		
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/kg x weight (kg) = _____ mg		
IV in 100 mL NS over 30 minutes on <b>Day 1</b> .		
NOTE: The dose for patients weighing greater than 100 kg should be calculated based on a weight of 100 kg.		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book chemo on Day 1.		
<input type="checkbox"/> Last Cycle. Return in _____ week(s).		
<b>CBC &amp; Diff, platelets</b> prior to Day 1 of each cycle		
<input type="checkbox"/> If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> ALT <input type="checkbox"/> <b>total</b> bilirubin		
<input type="checkbox"/> <b>HBV viral load every 3 months</b> <input type="checkbox"/> <b>HBsAg every 3 months</b>		
<input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE</b>		
		<b>SIGNATURE:</b> UC:s