



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: LYCLLCVPR Page 1 of 3

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 and Platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L				
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 prior to treatment				
dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO prior to treatment				
<input type="checkbox"/> Other: _____				
CHEMOTHERAPY:				
predniSONE 100 mg PO daily in AM on days 1 to 5.				
vinCRistine 1.4 mg/m ² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV in 50 mL NS over 15 mins.				
cyclophosphamide 1000 mg/m ² x BSA = _____ mg				
IV in 100 to 250 mL NS over 20 minutes to 1 hour.				
RITUXIMAB WITHIN 72 HOURS OF CVP				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
<u>For intravenous riTUXimab infusion:</u>				
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				
predniSONE as ordered for the LYCLLCVPR protocol				
<u>For subcutaneous riTUXimab injection:</u>				
diphenhydrAMINE 50 mg PO prior to riTUXimab subcutaneous				
acetaminophen 650 mg to 975 mg PO prior to riTUXimab subcutaneous				
predniSONE as ordered for the LYCLLCVPR protocol				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	



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Date:

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

TREATMENT: (continued) CYCLE 1 ONLY:

riTUXimab (first dose) 375 mg/m² x BSA = _____ mg
IV in 250 to 500 mL NS within 72 hours after day 1 of CVP.

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/hour. After 1 hour, increase rate by 50 mg/hr 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.

riTUXimab for subsequent treatments on CYCLES 2 to 8:

Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:

riTUXimab **subcut (RITUXAN SC) 1600 mg (fixed dose in 13.4 mL) subcutaneously** into abdomen over 7 minutes. Observe for 15 minutes after administration.

NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible

OR

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 500 mg/m² 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		

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. Constant visual observation is not required.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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Date:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in <input type="checkbox"/> three or <input type="checkbox"/> four weeks (select one) for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
CBC & Diff, platelets prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: