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: LYCVPO

(Induction Cycles 2 to 6)

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** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 0.8 x 10^9/L and platelets greater than or equal to 80 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 _____.

PREMEDICATIONS FOR vinCRIStine and cyclophosphamide:

ondansetron 8 mg PO prior to treatment.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO prior to treatment. If dexamethasone has been given the same day for the oBINutuzumab premedication, then omit.

PREMEDICATIONS FOR oBINutuzumab INFUSION:

30 minutes prior to infusion, repeat in 4 hours if infusion exceeds 4 hours:

acetaminophen 650 to 975 mg PO

diphenhydrAMINE 50 mg PO

If previous oBINutuzumab reaction was Grade 3, or if lymphocyte count greater than 25 x 10^9/L before treatment:

60 minutes prior to infusion, repeat in 4 hours if infusion exceeds 4 hours:

☐ **dexamethasone 20 mg IV** in 50 mL NS over 15 minutes

☐ **Other:**

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

TREATMENT:

Days 1 to 5:

predniSONE 100 mg PO daily in AM on **Days 1 to 5**.

Day 1:

vinCRIStine 1.4 mg/m^2 x BSA =_____mg on **Day 1.**

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

IV in 50 mL NS over 15 mins.

cyclophosphamide 1000 mg/m^2 x BSA = _____mg on **Day 1.**

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

IV in 100 to 250 mL NS over 20 minutes to 1 hour.

oBINutuzumab 1000 mg IV in 250 mL NS on **Day 1**. If no infusion reaction or only Grade 1 infusion reaction in the previous infusion and final infusion rate 100 mg/h or faster: Start at **100 mg/h**. Increase by 100 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

Vital signs prior to start of infusion, and as clinically indicated during and post infusion.

Refer to protocol for resuming infusion following a reaction

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

(Induction Cycles 2 to 6)

DATE:	
RETURN APPOINTMENT ORDERS	
Return in **three** weeks for Doctor and Cycle _____. Book chemo for Day 1 only. ☐ Cycle 6: Return in **two** months (calculate in months, not weeks) for Doctor and Cycle 7. Book chemo for Day 1 only.	
CBC & Diff prior to Day 1 of each cycle If clinically indicated: ☐ **creatinine** ☐ **ALT** ☐ **total bilirubin** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**