



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: LYCVPO Page 1 of 1
(Maintenance Cycles 7 to 18)

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 day of treatment					
May proceed with doses as written if within 96 hours ANC greater than or equal to 0.8 x 10⁹/L and platelets greater than or equal to 80 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 _____.					
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:					
<input type="checkbox"/> dexamethasone 20 mg IV in 50 mL NS over 15 minutes					
<input type="checkbox"/> Other:					
** Have Hypersensitivity Reaction Tray and Protocol Available**					
TREATMENT:					
oBINutuzumab 1000 mg IV in 250 mL NS on Day 1 . If no infusion reaction or only Grade 1 infusion reaction only 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.					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Cycle 7 to 17: Return in two months (calculate in months, not weeks) for Doctor and Cycle _____. Book chemo for Day 1 only.					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff prior to Day 1 of each cycle					
If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> ALT <input type="checkbox"/> total bilirubin					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: