BC CANCER
Provincial Health Services Authority

PROTOCOL CODE: LYGDPO   Page 1 of 1
(Maintenance Cycles 7 to 18)

DOCTOR'S ORDERS	Ht_____cm Wt_____kg BSA_____m²

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 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 10⁹/L** and **platelets greater than or equal to 80 x 10⁹/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 oBINutuzumab INFUSION:

☐ If previous oBINutuzumab reaction was Grade 3, or if lymphocyte count greater than 25 x 10⁹/L before Day 1 of current cycle, then 60 minutes prior to infusion: **dexamethasone 20 mg** IV

30 minutes prior to infusion: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** PO

☐ **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.

RETURN APPOINTMENT ORDERS

☐ Cycle 7 to 17: Return in **two** months (calculate in months, not weeks) for Doctor and Cycle _____.
Book treatment for Day 1 only.

☐ Last Cycle. Return in _____ week(s).

CBC & Diff prior to Day 1 of each cycle

If clinically indicated:

☐ **ALT**   ☐ **HBV viral load**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:	SIGNATURE: UC: