

PROTOCOL CODE: LYCLLFLUDR

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, Platelets, Creatinine 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, Creatinine within normal limits			
Note: If the patient has a serum creatinine above normal and for all patients above the age of 60 years, calculated creatinine clearance is required prior to first cycle of fludarabine, but is only required in subsequent cycles if the serum creatinine is above the normal range.			
Note: If the fludarabine dose was initially reduced, and is well tolerated, the dose may be increased in subsequent cycles regardless of renal function.			
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____			
Proceed with treatment based on blood work from _____			
TREATMENT:			
<u>Standard Dose:</u> Oral fludarabine 40 mg/m²/day x BSA = _____ mg PO daily for 5 consecutive days . Round dose to nearest 10 mg. (Note: PO fludarabine and riTUXimab to start on the same day). OR <u>Dose Modification Required:</u> Oral fludarabine 32 mg/m²/day x BSA = _____ mg PO daily for 3 consecutive days . Round dose to nearest 10 mg. (Note: PO fludarabine and riTUXimab to start on the same day) OR <u>Standard Dose:</u> IV fludarabine 25 mg/m²/day x BSA = _____ mg IV in 100 mL NS over 30 minutes daily for 5 days . (Note: riTUXimab to be given within 72 hours of IV fludarabine) OR <u>Dose Modification Required:</u> IV fludarabine 20 mg/m²/day x BSA = _____ mg IV in 100 mL NS over 30 minutes daily for 3 days . (Note: riTUXimab to be given within 72 hours of IV fludarabine)			
(Continued on Page 2)			
DOCTOR'S SIGNATURE:			SIGNATURE: UC:

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DOCTOR'S ORDERS

Date:

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

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

For intravenous riTUXimab infusion:

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

For subcutaneous riTUXimab injection:

diphenhydrAMINE 50 mg PO prior to riTUXimab subcutaneous

acetaminophen 650 mg to 975 mg PO prior to riTUXimab subcutaneous

Other

TREATMENT: (continued)

riTUXimab IV or subcutaneous may be given before or after chemotherapy, but within 72 hours after Day 1 of fludarabine

TREATMENT #1:

riTUXimab (first dose) 375 mg/m² x BSA = _____ mg

IV in 250 to 500 mL NS within 72 hours after Day 1 of fludarabine.

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

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SIGNATURE:

UC:

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DOCTOR'S ORDERS							
Date:							
Have Hypersensitivity Reaction Tray and Protocol Available							
<p>TREATMENT: (continued):</p> <p>FOR CYCLE 2 AND ALL SUBSEQUENT TREATMENTS:</p> <p><input type="checkbox"/> Patient tolerated a full dose of IV riTUXimab (no severe reactions requiring early termination) and can proceed to subcutaneous riTUXimab:</p> <p>riTUXimab subcut (RITUXAN SC) 1600 mg (fixed dose in 13.4 mL) subcutaneously into abdomen over 7 minutes. Observe for 15 minutes after administration.</p> <p>NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.</p> <p>OR</p> <p><input type="checkbox"/> 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:</p> <p>riTUXimab 500 mg/m² x BSA = _____ mg</p> <p>IV in 250 to 500 mL NS on day 1 of PO fludarabine OR within 72 hours after Day 1 of IV fludarabine.</p> <p>Pharmacy to select riTUXimab IV brand as per Provincial Systemic Therapy Policy III-190</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 20%;">Drug</th> <th style="width: 40%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">riTUXimab</td> <td></td> <td></td> </tr> </tbody> </table> <p>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)</p> <p>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.</p>		Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	riTUXimab		
Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date					
riTUXimab							
RETURN APPOINTMENT ORDERS							
<p><input type="checkbox"/> Return in four weeks for Doctor and Cycle _____.</p> <p style="margin-left: 20px;"><input type="checkbox"/> For PO fludarabine, book chemo for riTUXimab treatment only.</p> <p style="margin-left: 20px;"><input type="checkbox"/> For IV fludarabine, book chemo x 5 days OR 3 days (<i>circle one</i>). Match to dose duration above) Note riTUXimab to be booked within 72 hours of IV Fludarabine.</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s).</p>							
<p>CBC & Diff, Platelets, Creatinine prior to each cycle</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p>							
DOCTOR'S SIGNATURE:	SIGNATURE:						
	UC:						