PROTOCOL CODE: LYOBCHLOR

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, Platelets** day of treatment

May proceed with doses as written if within 96 hours **Day 1 ANC greater than or equal to 1.2 x 10^9/L, 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 _____

TREATMENT:

☐ **Cycle 1 to Cycle 6:**
chlorambucil ☐ **0.5 mg/kg** or ☐ _____ mg/kg (select one) = _____mg PO for one dose on Day 1 and Day 15
Do NOT exceed 0.8 mg/kg every 2 weeks. Round dose to the nearest 2 mg.

PREMEDICATIONS FOR oBINutuzumab INFUSION:

Patient to take own **acetaminophen** and **diphenhydrAMINE** supply. RN/Pharmacist to confirm_____.
If ordered, ensure patient has taken steroid the day(s) prior to infusion.

☐ **Cycle 1: Day 1 and Day 2**
60 minutes prior to infusion:
dexamethasone 20 mg IV in 50 mL NS over 15 minutes
30 minutes prior to infusion:
acetaminophen 650 to 975 mg PO
diphenhydrAMINE 50 mg PO

☐ **Cycle 1: Day 8 and Day 15**
30 minutes prior to infusion:
acetaminophen 650 to 975 mg PO
diphenhydrAMINE 50 mg PO
If previous reaction was grade 3, or if lymphocyte count greater than 25 x 10^9/L before treatment:
60 minutes prior to infusion:
☐ **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

☐ **Cycles 2 to 6:**
30 minutes prior to infusion:
acetaminophen 650 to 975 mg PO
diphenhydrAMINE 50 mg PO
If previous reaction was grade 3, or if lymphocyte count greater than 25 x 10^9/L before treatment:
60 minutes prior to infusion:
☐ **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

(Continued on Page 2)

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

Date:

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

Treatment continued

☐ **Cycle 1: Day 1**
oBINutuzumab 100 mg IV in 100 mL NS. Administer over 4 hours at 25 mg/h. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

☐ **Cycle 1: Day 2**
oBINutuzumab 900 mg IV in 250 mL NS. Start at 50 mg/h. Increase by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Refer to protocol appendix for oBINutuzumab infusion rate titration table.

☐ **Cycle 1: Day 8 and Day 15**
oBINutuzumab 1000 mg IV in 250 mL NS. 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.

For Cycle 1 Day 1, vital signs prior to start of infusion, at hour 2 and then post infusion. For Days 2, 8 and 15, vital signs prior to start of infusion and at every increment of infusion rate and as clinically indicated post infusion.

Refer to protocol for resuming infusion following a reaction
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.

☐ **Cycle 2 to Cycle 6: Day 1 only**
oBINutuzumab 1000 mg IV in 250 mL NS. 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.

For Cycle 2 to Cycle 6: Vitals signs prior to start of infusion, and as clinically indicated during and post infusion
Refer to protocol for resuming infusion following a reaction
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.

RETURN APPOINTMENT ORDERS

For Cycle 1, book chemo on Day 1, Day 2, Day 8 and Day 15.
☐ Return in **four** weeks for Doctor and Cycle _____.
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets prior to each cycle

☐ If clinically indicated: ☐ **Phosphate** ☐ **Potassium** ☐ **Calcium** ☐ **Uric acid**

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: