PROTOCOL CODE: LYRMTN

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:** **Maintenance dose #**

☐ Delay treatment _____ week(s)
☐ **CBC & Diff and Platelets** day of treatment

May proceed with doses as written if within 1 week **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L**
☐ **Proceed with treatment based on blood work from _____**

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
☐ **predniSONE 50 mg** PO prior to riTUXimab PRN

For subcutaneous riTUXimab injection:
diphenhydrAMINE 50 mg PO prior to **riTUXimab subcutaneous**
acetaminophen 650 mg to 975 mg PO prior to **riTUXimab subcutaneous**
☐ **predniSONE 50 mg** PO prior to riTUXimab PRN

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

TREATMENT:

☐ Patient on IV riTUXimab during active treatment:

riTUXimab 375 mg/m^2 x BSA = _____ mg

IV in 250 to 500 mL NS over 1 hour 30 minutes. 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.

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		

For maintenance dose # 1, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion completed. For all subsequent maintenance doses (# 2-8), constant visual observation is not required. Vital signs are not required unless symptomatic.

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.

Patient may leave if stable when infusion completed.

(Continued on page 2)

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

PROTOCOL CODE: LYRMTN

DATE:	
☐ Patient on subcutaneous riTUXimab during active treatment: **riTUXimab subcut (RITUXAN SC) 1400 mg (fixed dose in 11.7 mL) subcutaneously** into abdomen over 5 minutes. Observe for 15 minutes after administration. NB: During treatment with subcutaneous riTUXimab, administer other subcutaneous drugs at alternative injection sites whenever possible.	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** months (calculate in months, not weeks) for Doctor and next dose of maintenance riTUXimab. ☐ Last dose. Return in _____ months	
CBC & Diff, platelets prior to each treatment. ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**