CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg - bendamustine 70 - cytarabine 800

Regimen: Cycles 2-6 (Part I)

ARIA Protocol Name: Rituximab SC - Bendamustine 70 Cytarabine 800

Adult Chemotherapy - Hematology Oncology

Mantle Cell Lymphoma

Name:

HCN:

Date of Birth:

CC5890 0399 08 2023

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **dexamethasone 8 mg PO/IV** pre riTUXimab-hyaluronidase on day 1

☐ **diphenhydrAMINE 50 mg PO/IV** pre riTUXimab-hyaluronidase on day 1

☐ **acetaminophen 650 mg PO** pre riTUXimab-hyaluronidase on day 1

☐ **dexamethasone 8 mg PO/IV** pre chemotherapy on days 2, 3 and 4

☐ **ondansetron 8 mg PO/IV** pre chemotherapy on days 2, 3 and 4

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

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Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg
- bendamustine 70
- cytarabine 800

Regimen: Cycles 2-6 (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Rituximab SC – Bendamustine 70 Cytarabine 800

Adult Chemotherapy - Hematology Oncology

Mantle Cell Lymphoma

CC5890 0399 08 2023

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **riTUXimab-hyaluronidase,human 1400 mg**

SC over 5 minutes on day 1

☐ **bendamustine 70 mg/m^2** X BSA **=** _____ **mg**

☐ Dose modification: **bendamustine 70 mg/m^2** X BSA - _____% =_____ **mg**

IV in 500 mL normal saline over 60 minutes on day 2 and 3.

☐ **cytarabine 800 mg/m^2** X BSA **=** _____ **mg**

☐ Dose modification: **cytarabine 800 mg/m^2** X BSA - _____% =_____ **mg**

IV in 500 mL normal saline over 120 minutes on day 2, 3 and 4.

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 4 mg PO** once daily in the evening on day 2, 3 and 4

☐ **dexamethasone 4 mg PO** twice daily on day 5 and 6

☐ **metoclopramide 10-20 mg PO** every 4 hours as needed

☐ Other: _____

POST-CHEMOTHERAPY (FOR COMMUNITY PHARMACY)

☐ **filgrastim** (Brand: _____) _____**mcg subcutaneous** daily for 7 days starting on day 5 (24 hours post-chemotherapy)

☐ **pegfilgrastim** (Brand: _____) **6 mg subcutaneous** ONCE on day 5 (24 hours post-chemotherapy)

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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