Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg - gemcitabine 1000 - oxaliplatin 100

Regimen: Cycles 2-8 (Part I)

ARIA Protocol Name: rituximab SC gemcitabine oxaliplatin

Adult Chemotherapy - Hematology Oncology

Diffuse Large B Cell Lymphoma

Name:

HCN:

Date of Birth:

CC5980 0408 09 2023

Allergies: ☐ **No Known**

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

Cycle_______ of ______ **Cycle Duration: 14 days** Date of previous cycle: DD/MONTH/YYYY ________

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.0 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):

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

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

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

☐ **ondansetron 8 mg PO** pre chemotherapy on day 1

☐ 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.

Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg - gemcitabine 1000 - oxaliplatin 100

Regimen: Cycles 2-8 (Part II)

ARIA Protocol Name: rituximab SC gemcitabine oxaliplatin

Adult Chemotherapy - Hematology Oncology

Diffuse Large B Cell Lymphoma

Name:

HCN:

Date of Birth:

CC5980 0408 00/2023

Weight: ____________kg Height:________________cm Body Surface Area (BSA) = ___________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

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

SC over 5 minutes on day 1

☐ **gemcitabine 1000 mg/m²** X BSA = __________ **mg**

☐ Dose modification: **gemcitabine 1000 mg/m²** X BSA - _________% = __________ **mg**

IV in 250 mL normal saline over 30 minutes on days 1.

☐ **OXALIplatin 100 mg/m²** X BSA = __________ **mg**

☐ Dose modification: **OXALIplatin 100 mg/m²** X BSA - _________% = __________ **mg**

IV in 500 mL D5W over 120 minutes on day 1

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 4 mg PO** once daily in the evening on day 1

☐ **dexamethasone 4 mg PO** twice daily on days 2 and 3.

☐ **metoclopramide 10-20 mg PO** every 6 hours as needed

☐ 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.