

**Ruxience® (riTUXimab) 375 -
gemcitabine 1000 -
oxaliplatin 100**

Regimen: Part I

ARIA Protocol Name: Ruxience (rituximab) gemcitabine oxaliplatin

Adult Chemotherapy - Hematology Oncology

Diffuse Large B Cell Lymphoma



CC5970 0407 09 2023

Name: _____

HCN: _____

Date of Birth: _____

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 10⁹/L and platelets **greater than or equal to** 100 X 10⁹/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment complete.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- acetaminophen 650 mg PO pre riTUXimab on day 1
- diphenhydrAMINE 50 mg PO pre riTUXimab on day 1
- dexamethasone 8 mg PO pre riTUXimab on day 1
- ondansetron 8 mg PO pre chemotherapy on day 1
- allopurinol 300 mg PO on day 1 (for cycle 1 only)
- Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

- acetaminophen 650 mg PO prn x 1 dose (Give during riTUXimab infusion if infusion lasts greater than 4 hours)
- diphenhydrAMINE 50 mg PO prn x 1 dose (Give during riTUXimab infusion if infusion lasts greater than 4 hours)
- meperidine 25-50 mg IV q1h prn x 2 doses (For chills and rigors associated with riTUXimab)
- 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.



Doctor's Order Sheet

**Ruxience™ (riTUXimab) 375 -
gemcitabine 1000 -
oxaliplatin 100**

Regimen: Part II

ARIA Protocol Name: Ruxience (rituximab) gemcitabine oxaliplatin

Adult Chemotherapy - Hematology Oncology

Diffuse Large B Cell Lymphoma

Name: _____

HCN: _____

Date of Birth: _____



CC5970 0407 09/2023

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

Ruxience™ (riTUXimab) 375 mg/m² X BSA = _____ mg

Dose modification: **Ruxience™ (riTUXimab) 375 mg/m² X BSA - _____ % = _____ mg**

IV diluted to 1mg/ml in normal saline and administer as per protocol on day 1 during first dose or patient who experienced a previous reaction. Subsequent infusions (if no previous reaction and not using subcutaneous rituximab option) dilute in 250 mL normal saline, infuse 20% of total volume over 30 minutes, then remaining volume over 60 minutes. Observe patient for 30 minutes after infusion is complete.

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):

allopurinol 300 mg PO once daily on days 2 to 5 (for cycle 1 only)

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: _____

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