CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Ruxience® (riTUXimab) 500 - idelalisib 150 mg

Regimen: Cycles 2-8 (Part I)

ARIA Protocol Name: Ruxience (rituximab) idelalisib

Adult Chemotherapy - Hematology Oncology

Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL)

Name:

HCN:

Date of Birth:

CC6330 0443 01/2024

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** 0.5 X 10^9/L and platelets **greater than or equal to** 25 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

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

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

☐ 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

Ruxience® (riTUXimab) 500 - idelalisib 150 mg

Regimen: Cycles 2-8 (Part II)

ARIA Protocol Name: Ruxience (rituximab) idelalisib

Adult Chemotherapy - Hematology Oncology

Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL)

CC6330 0443 01/2024

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Ruxience™ (riTUXimab) 500 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.

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **idelalisib 150 mg PO** twice daily continuously

☐ Dose modification: **idelalisib 100 mg PO** twice daily continuously

Mitte: 30 days

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ **sulfamethoxazole/trimethoprim 400/80 mg PO** once daily for duration of treatment and 2 to 6 months after completion of treatment

☐ 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: _____