PENNSTATE HERSHEY
Cancer Institute

CHOP + RITUXIMAB

Revised: September 2014

Date written _____ To begin _____

Patient's: Height_____cm Weight_____kg BSA_____m^2
Allergies: ☐No ☐Yes: _____ Diagnosis_____ Metastatic Site _____

Cycle # _____ of _____ Planned

		If chemo delayed
Day	1	
Date		
Weight/BSA		
WBC/ANC		
Hb/Hct		
Platelets		
Dose delayed or not given (reason)		
RN Signature		

1. Laboratory Studies: CBC, DIFF, PLT
Notify MD if ANC <1500 or PLT <100K
Additional labs needed prior to chemo:_____
RN to record labs and other information requested on grid, and sign

2. Consent Obtained?
☐ Yes: ☐ Preprinted Consent

3. Infusion Room General Order Set will be initiated
4. Premedications:
Dexamethasone 20 mg po
Ondansetron 16 mg po 30 min prior to chemo

_____

_____

4. Chemotherapy:

Doxorubicin ☐ Full dose: 50mg/m^2=_____mg

☐ Instead of full dose, give _____% of dose = _____ mg Reason:_____
IV push

Vincristine ☐ Full dose: 1.4 mg/m^2=_____mg (max 2 mg)

☐ Instead of full dose, give _____% of dose = _____ mg Reason:_____
IV push

Cyclophosphamide ☐ Full dose: 750 mg/m^2=_____mg

☐ Instead of full dose, give _____% of dose = _____ mg Reason:_____
IV infuse over 30 min

Prednisone 100 mg po daily x 5 days (Requires Rx)

Rituximab 375 mg/m^2: See attached

5. Growth factor: ☐ None
☐ pegfilgrastim 6 mg subcutaneously day 2 or 3 of chemo regimen

Preparer's Signature _____ Date_____

Attending's Signature Printed name Pager number Date Time AM/PM

MR CHEMO ORDER

PENNSTATE HERSHEY
Cancer Institute

REVISED: September 2014

RITUXIMAB

Date written _____ To begin _____Weekly x4 or single dose

Patient's: Height_____cm Weight_____kg BSA_____m^2
Allergies: ☐No ☐Yes: _____ Diagnosis _____Metastatic Site

1. Laboratory Studies: CBC, DIFF, PLT prior to each infusion. Record results in grid
2. May Begin infusion before labs available. RN to record labs and other information requested on grid, and sign.
3. Call MD if WBC <2500 Hb <9.5 Plts <75,000.

Dose #	**1**	**2**	**3**	**4**
Date				
WBC/ANC				
Hb/Hct				
Platelets				
Type of infusion (circle one)	Standard Rapid: in 250ml	Standard Rapid: in 250ml	Standard Rapid: in 250 ml	Standard Rapid: in 250 ml
RN signature				

3. Consent Obtained?
   ☐ Yes ☐ Preprinted Consent
4. Infusion Room General Order Set will be initiated
5. Place IV if no indwelling catheter.
6. Pre-medicate prior to each infusion with:
   Diphenhydramine 50 mg po **Dexamethasone 20 mg po** (Unless Dexamethasone given within 24 hrs as part of a chemo regimen)
   Acetaminophen 650 mg po (give only if administering rituximab by **rapid** infusion)

Rituximab 375 mg/m^2 = _____mg (round to the nearest 50 mg)
☐ Give weekly x 4 doses
☐ Give as part of a chemotherapy regimen (see attached chemo order)
☐ Give as a single dose (or for maintenance treatment)

Standard Infusion:
-Prepare as a standard 2mg per ml solution
-Infuse initial dose of rituximab at 25 ml/hr x 30 minutes.
-If tolerated without symptoms, increase infusion rate by 25 ml/hr every 30 minutes to a maximum of 200 ml/hr

Rapid Infusion
-If the last rituximab infusion was well tolerated within the last 30 days (RN assessment: patient comfortable, no rigors, hypotension, urticaria or shortness of breath), then use:
-Mix rituximab dose in 250 ml normal saline and infuse first 50 ml over 30 minutes
-Then give remainder of rituximab over 60 minutes
-<u>This will require pre-medication with dexamethasone.</u>

Intermediate Infusion
- If the last rituximab infusion was well tolerated >30days ago (RN assessment: patient comfortable, no rigors, hypotension, urticaria or shortness of breath), then use
-Prepare as a standard 2mg per ml solution
-infusion may begin at 50 ml/hr for the first 30 minutes then increase by 50ml/hr every 30 minutes to maximum rate of 200 ml/hr.

If any symptoms occur, hold infusion, start NS at 100ml per hour. As appropriate, call MD and give
Meperidine 25 mg IV push for rigors, may repeat once if no improvement in 10 minutes
Diphenhydramine 25 mg IV push for urticaria/swelling, may repeat once if no relief in 10 minutes
Dexamethasone 20 mg IV for stridor, new wheezing or patient complaining of difficulty breathing.

Preparer's Signature _____ Date_____

Attending's Signature **Printed name** **Pager number** **Date** **Time AM/PM**

MR CHEMO ORDER