Trust location:_____

Parenteral Cytotoxic Chart

Chemocare prescription V1.01

Patient Details

Forename | Surname

DOB | Patient NO | Local No.

Consultant | Ward

NHS No

Protocol: R-CEOP (TRUXIMA)

Course Name: CEOP+ RITUXIMAB (TRUXIMA) 21d CYCLE NHL

Type of line / No. of lumen:

Diagnosis

SA (m²)
Height (m)
Weight (kg)

Monitoring	Acceptable Range		Date Due	Date of Test	Value	Checked
Height (m)						
Weight (kg)						
SA (m²)						
ANC >1 (5 day expiry)	1.00	15.00	Day [1]			
BILIRUBIN 1.5ULN	0.00	31.50	Day [1]			
CREATININE(max 130)	0.00	130.00	Day [1]			
PLATELETS > 100	100.00	600.00	Day [1]			

Additional Prescribing Notes

Please prescribe supportive/preventative care either on Chemocare or on a separate paper prescription, as per local trust policy and guidance:

1) Consider stress ulcer PPI prophylaxis i.e. lansoprazole.
2) Consider allopurinol 300mg OD (100mg OD if CrCl <20mls/min) for first 4 weeks of treatment only.
3) Consider aciclovir 200mg TDS and co-trimoxazole 960mg M,W,F.

Administration of rituximab infusions: Refer to and follow Trust guidelines.

Day	Date and Time	Drug and dose (per m2) or dose (per kg)	ACTUAL DOSE	Infusion Fluid and Final Volume	Route	Additives	Time/Infusion Rate	Line	Given/ Checked by	Time Start/ Stop	Comments
1	T=hrs	PREDNISOLONE (100mg)	100 mg	None	**PO**				Batch No.		Should be given 30-60 minutes prior to rituxumab infusion from take home supply or ward stock.
1	T=hrs	HYDROCORTISONE (100mg)	100 mg	None	**IV**		Slow Bolus		Batch No.		Can be administered in addition to oral prednisolone if required.
1	T=hrs	PARACETAMOL (1000mg)	1000 mg		**PO**				Batch No.		Should be given 30-60 minutes prior to rituximab infusion.
1	T=hrs	CHLORPHENAMINE (10mg)	10 mg		**IV**		Slow Bolus		Batch No.		Should be given 30-60 minutes prior to rituximab infusion.

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**
Date:	**Date:** / /	**Date:** / /	**Date:** / /

Parenteral 2
Intrathecal 0
Oral 3

Trust location:_____

Parenteral Cytotoxic Chart

Chemocare prescription V1.01

Patient Details

Forename

Surname

Protocol: R-CEOP (TRUXIMA)

DOB | Patient NO | Local No.

Course Name: CEOP+ RITUXIMAB (TRUXIMA) 21d CYCLE NHL

SA (m²)
Height (m)
Weight (kg)

Ward

NHS No

Day	Date and Time	Drug and dose (per m2) or dose (per kg)	ACTUAL DOSE	Infusion Fluid and Final Volume	Route	Additives	Time/Infusion Rate	Line	Given/ Checked by	Time Start/ Stop	Comments
1	T=hrs	RITUXIMAB (TRUXIMA) (375mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	IV				Batch No.		Truxima brand. Variable infusion rate - see additional prescribing notes.
1	T=hrs	FREE FLOWING INFUSION (500ml)	500 ml	SODIUM CHLORIDE 0.9%	IV				Batch No.		
1	T=hrs	ONDANSETRON (8mg)	8 mg	None	PO				Batch No.		
1	T=:hrs	**CYCLOPHOSPHAMIDE** (750mg/m²)	mg	None	IV		Slow Bolus		Batch No.		
1	T=:hrs	**ETOPOSIDE** (50mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	IV		Infuse over 1 Hrs at a rate 500 ml/hr		Batch No.		
1	T=:hrs	**VINCRISTINE** (1.4mg/m²)	mg	SODIUM CHLORIDE 0.9% 50 ml	IV				Batch No.		Infuse over 5-10 minutes. Monitor for signs of extravasation and report any incidents as per trust procedure.

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**
Date:	**Date:** / /	**Date:** / /	**Date:** / /

Patient Details

Forename	**Surname**	**Protocol**	R-CEOP (TRUXIMA)	**SA (m²)**
		Course Name	CEOP+ RITUXIMAB (TRUXIMA) 21d CYCLE NHL	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
Consultant		**Ward**	**Diagnosis**	
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	PREDNISOLONE																	
Actual dose	100 mg	**Duration**	5 DAYS															
Route	PO	**Start Date**																
Frequency	OM	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Taken preferably in the morning. First dose to be taken before the rituximab infusion.																	
Drug & dose	METOCLOPRAMIDE																	
Actual dose	10 mg	**Duration**	PRN															
Route	PO	**Start Date**																
Frequency	TDS	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Metoclopramide 10mg tablets are prescribed with each cycle, discuss with patient and delete if supply not required. If pre-pack supplied record Batch Number :_____.																	

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**	
Date:	**Date:** / /	**Date:** / /	**Date:** / /	**Chart Id.:**

Patient Details

Forename	**Surname**	**Protocol**	R-CEOP (TRUXIMA)	**SA (m²)**
		Course Name	CEOP+ RITUXIMAB (TRUXIMA) 21d CYCLE NHL	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
		Ward		
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	ONDANSETRON																	
Actual dose	8 mg	**Duration**	2 DAYS															
Route	PO	**Start Date**																
Frequency	BD	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	If pre-pack supplied record Batch Number :_____.																	
Drug & dose	**ETOPOSIDE**																	
Actual dose	mg	**Duration**	2 DAYS															
Route	PO	**Start Date**																
Frequency	OD	**Start Day**	2															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note																		

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**	
Date:	**Date:** / /	**Date:** / /	**Date:** / /	

Patient Details

Forename	**Surname**	**Protocol**	R-CEOP (TRUXIMA)	**SA (m²)**
		Course Name	CEOP+ RITUXIMAB (TRUXIMA) 21d CYCLE NHL	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
		Ward		
Address				

Record drug allergies or sensitivities

				Time	**Date**														
Drug & dose	FILGRASTIM (G-CSF)																		
Actual dose	microgram	**Duration**	3 DAYS																
Route	SC	**Start Date**																	
Frequency	OD	**Start Day**	7																
Quantity Dispensed		**Dispensed by**																	
		Accuracy check																	
Note	SUBCUTANEOUS BOLUS To be injected ONCE a day by subcutaneous injection on days 7, 11 and 14.																		

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**	
Date:	**Date:** / /	**Date:** / /	**Date:** / /	