Trust location:_____

Parenteral Cytotoxic Chart

Chemocare Version 1.01

Patient Details

Forename | Surname

Protocol: IDELALISIB + RITUXIMAB (TRUXIMA)

DOB | Patient NO | Local No. | Course Name: Idelalisib 150mg BD+Ritux (Truxima) 500mg/m2 C5-8

SA (m²)
Height (m)
Weight (kg)

Consultant: VALIDATION | Ward | Type of line / No. of lumen: | Diagnosis: Chronic lymphocytic leukaemia/Small lymp

NHS No

Monitoring	Acceptable Range		Date Due	Date of Test	Value	Checked
Height (m)						
Weight (kg)						
SA (m²)						
ALA TRANSAM 3ULN	0.00	120.00	Day [1]			
NEUTROPHILS > 1.0	1.00	15.00	Day [1]			
PLATELETS> 75	75.00	600.00	Day [1]			

Additional Prescribing Notes

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	PARACETAMOL (1000mg)	1000 mg	None	PO				Batch No.		Should be given 30-60 minutes prior to rituximab infusion.
1	T=hrs	HYDROCORTISONE (100mg)	100 mg	None	IV		Slow Bolus		Batch No.		Should be given 30-60 minutes prior to rituximab infusion.
1	T=00Hhrs	CHLORPHENAMINE (10mg)	10 mg		IV		Slow Bolus		Batch No.		Should be given 30-60 minutes prior to rituximab infusion.
1	T=:hrs	RITUXIMAB (TRUXIMA) (500mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	IV				Batch No.		Variable infusion rate - follow Trust guidelines. Ensure patient has received chlorphenamine and paracetamol.

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

Parenteral 1
Intrathecal 0
Oral 2

Patient Details

Forename	**Surname**	**Protocol**	IDELALISIB + RITUXIMAB (TRUXIMA)	**SA (m²)**
		Course Name	Idelalisib 150mg BD+Ritux (Truxima) 500mg/m2 C5-8	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
Consultant		**Ward**	**Diagnosis** Chronic lymphocytic leukaemia/Small lymp	
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	IDELALISIB																	
Actual dose	150 mg	**Duration**	28 DAYS															
Route	PO	**Start Date**																
Frequency	BD	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Supply 1 original container of 60 tablets. Swallow whole with or without food.																	
Drug & dose	CO-TRIMOXAZOLE																	
Actual dose	960 mg	**Duration**	28 DAYS															
Route	PO	**Start Date**																
Frequency	OD M,W,F	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	960mg of Co-Trimoxazole to be taken on Mondays, Wednesdays and Fridays throughout treatment.																	

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

Patient Details

Forename	**Surname**	**Protocol**	IDELALISIB + RITUXIMAB (TRUXIMA)	**SA (m²)**
		Course Name	Idelalisib 150mg BD+Ritux (Truxima) 500mg/m2 C5-8	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
		Ward		
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	ACICLOVIR																	
Actual dose	200 mg	**Duration**	28 DAYS															
Route	PO	**Start Date**																
Frequency	TDS	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	If pre-pack supplied record Batch Number :_____.																	
Drug & dose	LOPERAMIDE																	
Actual dose	2 mg	**Duration**	SEE NOTE															
Route	PO	**Start Date**																
Frequency	SEE NOTE	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Take 4mg after first loose stool then 2mg after each loose stool thereafter upto maximum of 16mg in 24 hours. If pre-pack supplied, record Batch Number:_____																	

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