

Trust location: _____

Patient Details

Forename _____ Surname _____

DOB _____

Patient NO _____

Local No. _____

Consultant _____

NHS No _____

Protocol IDELALISIB + RITUXIMAB (RIXATHON)

Course Name: Idelalisib 150mg BD+Ritux (Rixathon) 500mg/m2 C4

Type of line _____

No. of lumen: _____

Diagnosis Chronic lymphocytic leukaemia/Small lymph

SA (m²) _____

Height (m) _____

Weight (kg) _____

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Monitoring	Acceptable Range		Date Due	Date of Test	Value	Checked	<div>Additional Prescribing Notes</div> <div>Administration of rituximab infusions: Refer to and follow Trust guidelines.</div>
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]				

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

Allocated by: _____

Date: _____

Confirmed by: _____

Date: _____

Authorised by: _____

Date: _____

Checked by: (Pharmacist) _____

Date: _____

Chart Id.: _____

Parenteral

Intrathecal

Oral

1

0

2

Patient Details

Forename	Surname		Protocol	IDELALISIB + RITUXIMAB (RIXATHON)										SA (m²)			
			Course Name	Idelalisib 150mg BD+Ritux (Rixathon) 500mg/m2 C4										Height (m)			
DOB	Patient NO		Local No.		NHS No								Weight (kg)				
Consultant			Ward		Diagnosis		Chronic lymphocytic leukaemia/Small lymph										
Address																	
Record drug allergies or sensitivities																	
				Time	Date												
Drug & dose	IDELALISIB																
Actual dose	150 mg		Duration	Ongoing													
Route	PO		Start Date														
Frequency	BD		Start Day	1													
Quantity Dispensed		Dispensed by															
		Accuracy check															
Note	SUPPLY NOT REQUIRED. 1 month of idelalisib supplied in cycle 3. Swallow whole with or without food.																
Drug & dose	CO-TRIMOXAZOLE																
Actual dose	960 mg		Duration	Ongoing													
Route	PO		Start Date														
Frequency	OD M,W,F		Start Day	1													
Quantity Dispensed		Dispensed by															
		Accuracy check															
Note	SUPPLY NOT REQUIRED. 28 days of co-trimoxazole supplied in cycle 3.																

Patient Details

Forename	Surname		Protocol	IDELALISIB + RITUXIMAB (RIXATHON)	SA (m²)
			Course Name	Idelalisib 150mg BD+Ritux (Rixathon) 500mg/m2 C4	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	Ongoing															
Route	PO	Start Date																
Frequency	TDS	Start Day	1															
Quantity Dispensed		Dispensed by																
		Accuracy check																
Note	SUPPLY NOT REQUIRED. 28 days of aciclovir supplied in cycle 3.																	
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)	Chart Id.:
Date:	Date:	Date:	Date:	
/ /	/ /	/ /	/ /	