



**Cladribine Rituximab**

**Condition For Which Treatment is proposed:** \_\_\_\_\_

1. I hereby authorize my physician, Dr \_\_\_\_\_, and/or such other staff physicians or resident physicians as my physician may designate, to administer to me (or the patient for whom I consent) the following chemotherapy consisting of:

**Cladribine  
Rituximab**

**The plan for my course of chemotherapy is for \_\_\_\_\_ cycles of chemotherapy, with each cycle given about every \_\_\_\_\_ days.**

2. My physician has discussed with me the items that are briefly summarized below:
- a. The nature and purpose of the proposed therapy is to administer chemotherapy (drugs to fight my cancer, which may also have other effects on my body) by mouth and/or by vein or by other type of injection.
  - b. The risks of the proposed chemotherapy:

**Chemotherapy** may cause nausea, vomiting, loss of appetite, mouth sores, hair loss, fatigue, a lowering of the white blood cell count (which can lead to a serious infections), a lowered platelet count (which can lead to bleeding), and a decrease in my red blood cell count (which can lead to shortness of breath, a rapid heart beat or weakness). Due to these low blood counts, I may require red blood cell or platelet transfusions. My doctor will give me appropriate medications to try to decrease the severity of any side effects. Other side effects could occur, rarely death. It is important that I call my physician or nurse-coordinator with problems which occur during the course of my treatment. I always have the right to refuse chemotherapy at any time. It is possible that this chemotherapy may not be effective and my disease might progress.

**Long-term side effects** of chemotherapy can include injury to lungs, heart, liver and/or bladder. Acute leukemia can also develop as a result of chemotherapy.

**Chemotherapy usually has an adverse effect on sperm and eggs** and can cause me to be unable to have children. Chemotherapy can have harmful effects on an unborn child. If I am a woman, it is important to tell my physician if I think I may be pregnant. It is possible to conceive a child during treatment with chemotherapy. It is important that both men and women who are being treated with chemotherapy and who are sexually active, fertile, and who have a fertile partner use a reliable form of birth control (birth control pills, a reliable barrier method or a hormonal implant.)

You (or the patient for whom you consent) may require **venipuncture** (putting a needle into a vein to remove blood or administer chemotherapy). The discomfort associated with venipuncture is a slight pinch or pinprick when the sterile needle enters the skin. The risks of venipuncture include mild discomfort and/or a black or blue mark at the site of the needle puncture. Less commonly, a small blood clot, infection or bleeding may occur at the needle puncture site. When chemotherapy is administered



into a vein, there is also a small risk of either infection in the bloodstream or the chemotherapy leaking outside the vein causing tissue irritation or damage.

**The drugs which will be used for my planned chemotherapy and their specific side-effects:**

**Cladribine:** Localized skin reaction at infusion site, rash (which could progress to a serious skin reaction, even a fatal skin reaction – rare, headache, fatigue, and fever. A decrease in kidney function, or decreased nerve conduction.

**Rituximab:**

**Likely reactions:** Reactions which may occur as the drug is being given include fever, chills and/or nausea which can be severe.

**Less likely reactions:**

- High blood pressure
- Low blood pressure
- Abnormal fast heartbeat
- Skin rashes or hives
- Itching
- Allergic reaction that may cause fever, aches and pain in the joints, skin rash and swollen lymph glands.
- Excess sweating or flushing
- Cough, shortness of breath or wheezing
- Stuffy or runny nose, sneezing
- Swelling of the lips, eyes, tongue and throat which can be severe.
- Swelling of the arms and legs
- Pain in the area of the tumor
- Severe hepatitis (liver infection) in those patients who are carriers of the hepatitis virus. Your doctor **may** screen you for the hepatitis virus before beginning treatment. If you test positive for the virus, you will be closely monitored for signs of the infection.
- Some other viral infection may be worsened or reactivated from a “sleeping” state in patients taking rituximab

**Rare, but serious side effects**

- Another viral infection, like those mentioned above, causes a serious brain condition called progressive multifocal leukoencephalopathy (PML). PML can be serious, causing severe disability or death.
- Skin rash that might be severe
- Severe reactions during rituximab infusions or severe allergic reaction: A fast heart rate, wheezing, low blood pressure, sweating, swelling of the throat and face rash may occur within a few minutes of starting treatment. They can be handled with medication and sometimes by slowing the rate infusion. The reactions are more common during the infusion of rituximab. You will be given medications to decrease the likelihood that the reactions may occur and decrease their severity if they should occur.
- Tumor Lysis Syndrome, a rapid decline in the number of tumor cells that can lead to kidney failure and/or chemical imbalances that may have an effect on other organs like your heart. If this were to occur, you would receive close monitoring and blood tests, as well as appropriate medical treatment
- Severe lung dysfunction resulting in an inability to breathe which can be life-threatening
- Potentially life-threatening condition effecting less than 10% of the skin in which cell death causes the epidermis (outer layer) to separate from the dermis (middle layer)



- Life threatening condition effecting greater than 30% of the skin in which cell death causes the epidermis (outer layer) to separate from the dermis (middle layer)

- The medically reasonable alternative treatments and the risks associated with these alternative treatments have been described by my physician. These alternatives include no treatment, combinations of different chemotherapy drugs, or the same drugs given in different doses or on a different schedule.
- Without the proposed treatment my disease may progress, it could remain stable or, rarely, improve.
- I understand that during the course of this chemotherapy, unforeseen conditions may arise which could require the planned chemotherapy to be altered. All alterations to the planned chemotherapy will be discussed with me.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed therapy.
- I acknowledge that the information I have received, as summarized on this form, is sufficient for me to consent to and authorize the chemotherapy described above. I have had the opportunity to ask questions concerning my condition, the chemotherapy, the alternatives and risks, and all questions have been answered to my satisfaction.
- I impose the following limitation(s) regarding my treatment (if none, so state): \_\_\_\_\_  
\_\_\_\_\_
- I authorize the staff of The Hershey Medical Center to preserve for scientific or teaching purposes any tissues or parts which may be removed in the course of this procedure, and to dispose of them.
- I authorize The Hershey Medical Center to permit other persons to observe this therapy with the understanding that such observation is for the purpose of advancing medical knowledge. I authorize The Hershey Medical Center to obtain photographic or other pictorial representations of this therapy, and to use such representations for scientific or teaching purposes.
- I certify that all blanks requiring insertion of information were completed before I signed this consent form.

\_\_\_\_\_ provided the information summarized above and obtained the  
(fill in name) consent for the procedure

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Patient's Signature) (Date) (Time)  
(or signature of person consenting on behalf of the patient)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Optional: Witness to Patient's Signature) (Date) (Time)

\_\_\_\_\_/\_\_\_\_\_  
(Physician's Signature) (Date)

