PENNSTATE HERSHEY
Cancer Institute

PHYSICIAN'S ORDER SHEET

BMT: Allogeneic BU(12)/FLU – (Intermediate Intensity)
Revised 6/23/14
Date Written _____ For _____

Diagnosis:_____
Allergies _____

Actual weight_____kg Height_____cm
Ideal weight _____kg Actual BSA_____m^2

Use the following for chemotherapy dosing:
Adjusted weight*_____kg Adjusted BSA_____m^2
* Adjusted weight = ideal weight + .25 (actual – ideal weight)

Verify height and weight upon admission; if >10% difference from above (actual) values, notify attending physician to recalculate doses (for drugs other than chemotherapy, use actual body weight)

Protocol:
No:
Source of Drug:
Routine Supply:

Activate Order Set: BMT Allo Intermediate Intensity Matched Donor

Draw Pre-treatment Labs (See lab orders)
Catheter care for appropriate device per protocol
All Blood Products must be leukopoor, irradiated

Day of Planned Admission: Day -7

On Admission
Diet: Regular until Day 0; then neutropenic
Activity: As tolerated. Starting after stem cell infusion: BMT precautions (mask) for visitors, mask for patient when out of room
Strict I & O & call H.O. if positive fluid balance over any 8 hour period
Daily AM weight

Prepared by _____ Date _____

Ordered by_____ Date _____ Noted/Time/Initial_____

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Medications:

Phenytoin 100 mg po every 8 hours – Days -7 through -2
(Suggested IV alternative Phenytoin 100 mg IV every 8 hours)
Ciprofloxacin 500 mg po bid
(Suggested IV alternative Ciprofloxacin 400 mg IV every 12 hours)

Recipient HSV status _____ Donor HSV status _____
Recipient CMV status _____ Donor CMV status _____

Acyclovir 400 mg po TID
(Suggested IV alternative: Acyclovir 250 mg/m^2 = _____ mg IV every 12 hours)

☐ Provera 10 mg po daily (for females having periods)
☐ Allopurinol 300 mg po daily (for possible tumor lysis)

Sulfamethoxazole-Trimethoprim DS 1 TAB orally BID every M-T-W
(Suggested IV alternative Sulfamethoxazole-Trimethoprim 160 mg of the Trimethoprim component IV every 12 hours every M-T-W)

Prochlorperazine 10 mg po every 4 hours prn for nausea
Prochlorperazine 10 mg IV every 4 hours prn for nausea if not tolerating oral meds

Lorazepam 1 mg po every 4 hours prn for nausea
Lorazepam 1 mg IV every 4 hours prn for nausea not tolerating oral meds

No Acetaminophen containing drugs for 72 hours prior to Busulfan infusion through day -2.

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Chemotherapy:

Review admission labs

☐ If labs normal – Proceed with Chemo, if abnormal call attending physician before proceeding with chemo

☐ Review labs with attending physician before proceeding with chemo

IV fluid: D5 ½ NS with 20 mEq KCL/liter @ ____ ml/hr start by 4pm and continue until stem cell infusion on day 0.

Day –7 _____ to Day –3_____
date date

Fludarabine 30 mg/m^2 = _____mg in 100 ml normal saline IV over 30 minutes every 24 hours days –7 through –3 (5 doses) (_____through_____)
date date

Day –7_____ to Day -4 _____
date date

Ondansetron 8mg po every 12 hours x 8 doses beginning thirty minutes before 1st dose of Busulfan

Busulfan 0.8mg/kg = _____mg IV <u>via central line only!!</u> over two hours every six hours for twelve doses: start at 10pm on day -7(_____) (total dose = 9.6mg/kg)
date

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Day –3_____
date

Tacrolimus 0.045 mg/kg (adjusted weight) rounded upward to the nearest total mg =_____ mg. Divide this dose into two equal doses. Give _____mg orally every day at 6 am and _____mg orally every day at 6 pm.

☐ **No Tacrolimus needed**

Day 0 _____
date

Day 0 – Prior to Blood product transfusion, refer to ABO compatibility memo

Number of Cells to be Reinfused for allogeneic stem cells:

(Circle One)
Two Million
Three Million
Four Million
Five Million
Infuse All **Other_____**

(Circle One) **Peripheral Blood**
Bone Marrow
Cord Blood

(Circle One) **Fresh**
Cryopreserved

1. **Scheduled for _____. At 9AM call _____ to arrange time of infusion. Call 7298 with time when established.**

2. **Premedications (To be used for Cryopreserved Cells)**
   ☐ **Ondansetron 8 mg, IV 30 minutes prior to infusion**

3. **Have available in room:**
   a. **Diphenhydramine 50 mg IV**
   b. **Epinephrine 10 ml syringe 1:10,000**
   c. **Furosemide 80 mg IV**
   d. Oxygen via nasal cannula

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e. Cardiac monitor with continuous O_2 monitoring with every 5 minute blood pressures during infusion then every 15 minutes; continue for 1 hour post-infusion.

f. Normal saline IV via macrodrip with one extension with clear – tube access connection.

g. Sterile gloves, sterile barrier, alcohol wipes in room.

h. After infusion:

a. **D5½ NS with 50 mEq of $NaHCO_3$ per liter and 20 mEq potassium chloride per liter to run 150 ml per hour for six hours.**

Begin BMT isolation.

Day 0_____ through Day +1 _____
date **date**

IV fluid: D5 ½ NS with 50 mEq $NaHCO_3$/liter @ 100 ml/hr day 0 (_____) through day +1(_____)
date **date**

Day +1 (_____), +3 (_____), +6 (_____)
date **date** **date**

Methotrexate 5 mg/m^2 IV push = _____mg day +1, +3, +6
(Clear with BMT attending physician or fellow before each dose, RN to document in progress note)

Day +7 _____
date

Filgrastim (GCSF) 5 mcg/kg =_____mcg subcutaneous daily beginning day +7(_____) until recovery of neutrophil count to >500/mcl x 1 value

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Lab Orders

Pre-treatment and every Monday: fasting lipid panel
On admission and every 48 hours: CBC with diff and plts (until plts <20, then daily), CMP, Mg, Phos
On admission and q Monday, Thursday: uric acid, retic count, PT, INR
Every Monday: Serum for CMV Antigen
Day-2(_____) and then daily Tacrolimus levels (target 5-10 ng/ml)
Day-1: Specimen to Blood Bank for Type and Cross with Transplant Donor

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MR CHEMO ORDER

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

Penn State Milton S. Hershey Medical Center
500 University Dr., PO Box 850
Hershey, PA 17033
(717) 531-8521

NAME _____ DOB_____ HT_____ WT _____

ADDRESS _____ DATE _____

PATIENT NO _____ ALLERGIES _____ INDICATION _____

Rx

☐ ≤ 45kg: Dispense 30ml of 125 mg/5ml suspension of phenytoin
5mg/kg=_____mg=_____ml of 125mg/5ml suspension.
Take _____ml po q8 hourly x 3 doses, begin the day before admission
Please provide an appropriate measuring tool to patient

☐ 45-60kg: phenytoin 100mg capsules # 9
Sig: 3 capsules po q8hour x 3 doses, begin the day before admission

☐ 61-80kg: phenytoin 100mg capsules #12
Sig: 3 capsules po q8 hours x 4 doses, begin the day before admission

☐ 81-100kg: phenytoin 100mg capsules #16
Sig: 4 capsules po q6 hours x 4 doses, begin the day before admission

☐ ≥100kg: phenytoin 100mg capsules #20
Sig: 4 capsules po q6 hours x 5 doses, begin the day before admission

_____
Name (Please Print) M.D./D.O.

_____ _____
License Number National Provider #

_____
D.E.A. Reg. No.

_____
SUBSTITUTION PREMISSIBLE M.D./D.O.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.