ORMC ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

Date 2/6/20	Time:	From: Dr. R Havel
Receiver's Name: Infusion Inbound **Phone Front Desk :845-333-1150** **Stacy phone : 845-333-1905** **Inbound Fax : 845-333-9400**		**Department:** Oncology **Phone:** 845-703-6999 **Fax :** 845-703-6288

Number of pages, including this coversheet:
Information Transmitted: 2

Appointment Date Needed: Next week

Name of Patient : Christina Moschetta

DOB: 2/22/69

MRN # :

Diagnosis written on Order: E75.21

Authorization Number : 56497988

Thank you

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Christine Moschetto DOB: 2/22/69

Date Written: 1/31/20 Date of Administration:

Diagnosis: Fabry D7 TNM Stage: Allergies: ☐ NKDA

Protocol / Regimen: Fabrazyme Cycle: 1 of: 3 Day:

Venous Access: ☐ Peripheral ☒ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 2 in	53 kg ☒ Actual ☒ Ideal ☒ Adjusted ☒ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters: ____

ANC less than: ____ WBC less than: ____ PLT less than: ____ Hgb/Hct less than: ____ SCr greater than: ____

Non-chemotherapy orders:	RPh initials / Nurse initials	
IV Fluids: ◯ Sodium Chloride 0.9% to KVO (20 mL/hr) ◯ Dextrose 5% to KVO (20 mL/hr)		
Please do antibody testing + GL-3 testing		
every 3 months for the first 18 months		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed *(Rounding to be completed by RPh)*	Route	Infusion Rate	RPh / Nurse Initials
Fabrazyme	1mg/kg		52		IV	See attached	
						Q2wks	

*If using a dose reduction, please provide rationale: ____

MD Name (Print): Ronen Harel MD Signature _____ Date/Time 1/31/20

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

FABRAZYME INFUSION ORDERS

VISIT #_____

Christina

DOB:
Diagnosis: Fabry Disease (E75.21)

Condition: Stable
Activity: ad lib
Allergies:_____
Bare Weight: 52 kg
Vital Signs: on admission, prior to infusion, at completion of infusion. If inpatient, q shift
Medications:

Infusion line to be primed with normal saline, use piggyback tubing set up.
Primary line for NS (50mL bag), piggyback line for Fabrazyme

No pre-meds

INFUSION:
55 mg of Fabrazyme@in 100 mL NSS (= 1 mg/kg ⇒ 55 mg)

I. 10cc/hr for 30 min
II. 20cc/hr for 60 min
III. 30cc/hr for the remainder) ≥ 4 hrs

When infusion bag almost empty add 20 cc NS to infusion bag and run. 40 mL/hr

If 250 cc NS bag is used, rate should be adjusted