

**FAX TRANSMISSION**

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

Number of pages, including this coversheet:Information Transmitted: 2Appointment Date Needed: Next weekName of Patient: Christina MoschettaDOB: 2/22/69

MRN #: _____

Diagnosis written on Order: E75.21Authorization Number: 58497988

Thank you

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CHEMOTHERAPY ORDERS

Patient Label

| TO BE COMPLETED BY PHYSICIAN: | | Patient Name: <u>Christine Moschetti</u> | | DOB: <u>2/22/69</u> | | | |
|---|---|---|-------------------------------------|--|-----------|---------------|-------------------------------------|
| Date Written: <u>1/31/20</u> | | Date of Administration: | | | | | |
| Diagnosis: <u>Falcy D7</u> | | TNM Stage: | | Allergies: <input type="checkbox"/> NKDA | | | |
| Protocol / Regimen: <u>Fabrazyme</u> | | Cycle: <u>1</u> of: <u>3</u> Day: <u>1</u> | | | | | |
| Venous Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central | | | | | | | |
| Height <u>5 ft 2 in</u> | Weight <u>53</u> kg | <input type="checkbox"/> Actual <input type="checkbox"/> Ideal <input type="checkbox"/> Adjusted <input type="checkbox"/> Dosing | Body Surface Area (m ²) | Emetic Level <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High | | | |
| Lab Orders: <input type="checkbox"/> CBC/DIFF <input type="checkbox"/> BMP <input type="checkbox"/> Magnesium <input type="checkbox"/> 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: <input type="radio"/> Sodium Chloride 0.9% to KVO (20 mL/hr) <input type="radio"/> Dextrose 5% to KVO (20 mL/hr) | | | | | | | |
| <u>Please do antibody testing + GL-3 testing every 3 months for the first 18 months</u> | | | | | | | |
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| 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 |
| <u>Fabrazyme</u> | <u>1mg/kg</u> | | <u>52</u> | | <u>IV</u> | | <u>See attached</u> <u>Q2wks</u> |
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*If using a dose reduction, please provide rationale:

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

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

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

From: Boston's Children To: Infusion Orders - Christina Moschetta

15:45 01/29/20 ET Pg 2-6

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 premeds

INFUSION:

55 mg of Fabrazyme in 100 mL NSS

- I. 10cc/hr for 30 min
- II. 20cc/hr for 60 min
- III. 30cc/hr for the remainder

($\approx 1 \text{ mg/kg} \Rightarrow 55 \text{ mg}$)
 $\approx 4 \text{ hrs}$

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