

**FAX TRANSMISSION**

Date: 2/16/20	Time:	From: Dr. R Harel
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: Alexandria Moschetti

DOB: 10/29/99

MRN #: _____

Diagnosis written on Order: E75.21

Authorization Number: 50497116

Thank you

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CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN:		Patient Name: <u>Alexandra MacCletts</u>		DOB: <u>10/25/97</u>			
Date Written: <u>1/31/20</u>		Date of Administration:					
Diagnosis: <u>Fabry DZ</u>		TNM Stage:		Allergies: <input type="checkbox"/> NKDA			
Protocol / Regimen: <u>Fabrazyme</u>		Cycle: of: Day: <u>1 3</u>					
Venous Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central							
Height <u>5 ft 4 in</u>	Weight <u>64 kg</u>	<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 + Plasma</u>							
<u>GL-3 testing every 3 months</u>							
<u>for the first 18 months</u>							
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>65mg</u>		<u>IV</u>	<u>see attached</u>	
						<u>Q 2 wks</u>	

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

MD Name (Print): Ronan Henry MD Signature: _____ Date/Time: _____

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

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

FABRAZYME INFUSION ORDERS

VISIT #

Alexandra

DOE:

Diagnosis: Fabry Disease (E75.21)

Condition: Stable

Activity: ad lib

Allergien: _____

Bare Weight: 64 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:

6.5 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

(1 mg/kg \Rightarrow 65 mg)
= 4 hr

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