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 : Alexandria Moschetta

DOB: 10/29/99

MRN # :

Diagnosis written on Order: E75.21

Authorization Number : 50497116

Thank you

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Alexandria Mascletta DOB: 10/25/9[illegible]

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

Diagnosis: Fabry Dz TNM Stage:

Allergies: ☐ NKDA

Protocol / Regimen: Fabrazyme

Cycle: of:

Day: 1 3

Venous Access: ☐ Peripheral ☐ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 4 in	64 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 & Plasma		
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		65mg		IV	See attached		
						Q 2 wks		

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

MD Name (Print): Ronen Herz MD Signature ____ Date/Time ____

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

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

FABRAZYME INFUSION ORDERS

VISIT #_____

Alexandra

DOB:

Diagnosis: Fabry Disease (E75.21)

Condition: Stable

Activity: ad lib

Allergies:_____

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

Nonpre-meds Ø

INFUSION:

65 mg of Fabrazyme in 100mL NSS (1 mg/kg ⇒ 65 mg)

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