UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST				HAEMATOLOGY CHEMOTHERAPY PRESCRIPTION		
Document Code:	HROTA 325	**Written by:**	Amritpal Atwal	**Authorised By:**	Consultant	Dr Lindsay George
Issue No:	1.0	**Issue date:**	February 2021		Clinical Nurse Specialist	Nicola Jones
Page:	1 of 5	**Valid until:**	Next review		Pharmacist	Nicola Marchant

Patient label:

Hb		**Na^+**		**Alb**		**Height**	
WCC		**K^+**		**Bili**		**Weight**	
Nts		**U**		**AlkPhos**		**B.S.A.**	
Plt		**Cr**		**ALT**			
		GFR					
		Ca					
		Mg					

Reference: UKALL 2011 Trial, interim guidelines

NON –TRIAL UKALL 2011
Regimen A Maintenance

Cycle……

Indication: ALL

The first cycle starts at the beginning of week 25. Patients should have neutrophils >0.75x10^9/L and platelets of >75x10^9/L. Each maintenance cycle runs for 12 weeks.

- Maintenance treatment is stopped exactly 2 years (for girls) or 3 years (for boys), from start of interim maintenance both ALL and LBL.
- **For patients receiving intrathecal methotrexate – omit the oral methotrexate dose in the week intrathecal methotrexate is given.**

DAY NO. *(Please circle)* DATE	DRUG or ELECTROLYTE	CALCULATION	DOSE	I.V. FLUID	VOLUME (ml)	FLOW RATE	SPECIAL DIRECTIONS	DRUG ADMINISTRATION sig.	sig.	TIME	Pharm
Day 1	**VINCRISTINE**	**1.5mg/m^2**	(max 2mg)	N/Saline	50	IV 10min					(Max 2mg)
	METHOTREXATE	**20mg/m^2**		PO			**ONCE a WEEK on days 1, 8 and 22** *Available as 2.5mg tablets only - round to nearest 2.5mg*				
	MERCAPTOPURINE	**75mg/m^2**		PO			**ONCE a Day for 4 weeks** *Available as 50mg tablets only - round to nearest 50mg.* Take at least 1 hour after evening meal without milk products				
	DEXAMETHASONE	**6mg/m^2/day** *in two divided doses*	AM / PM	PO			**On days 1 to 5** *Available as 0.5mg and 2mg tablets only – round to nearest 0.5mg. Take with or after food.*				
Day 15	***Intrathecal due – please prescribe on THROTA 134***										

Supportive medications:

DRUG	DOSE	ROUTE	Quantity to supply	Tick of required
Aciclovir	400mg BD	PO	2 x 56	
Co-trimoxazole	……..mg BD on sat/sun See page 5	PO	28 x 480mg	
Lansoprazole	30mg OD on days 1-5	PO	1 x 28	
Metoclopramide	10mg TDS PRN	PO	1 x 28 x 10mg	
Imatinib (ABL-class fusion)	400mg – 600mg OD	PO	Month's supply	

Prescriber Sig. …… Date: …… Chemo Nurse Sig. …… Date: …… Pharmacist Sig. …… Date: ……

Patient label:

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Regimen A Maintenance

DAY NO. *(Please circle)* DATE	DRUG or ELECTROLYTE	CALCULATION	DOSE	I.V. FLUID	VOLUME (ml)	FLOW RATE	SPECIAL DIRECTIONS	DRUG ADMINISTRATION sig.	sig.	TIME	Pharm
Day 29	VINCRISTINE	1.5mg/m^2	(max 2mg)	N/Saline	50	IV 10min					(max 2mg)
	METHOTREXATE	20mg/m^2		PO			**ONCE a WEEK for FOUR weeks** *Available as 2.5mg tablets only - round to nearest 2.5mg*				
	MERCAPTOPURINE	75mg/m^2		PO			**ONCE a Day for 4 weeks** *Available as 50mg tablets only - round to nearest 50mg.* Take at least 1 hour after evening meal without milk products				
	DEXAMETHASONE	6mg/m^2/day *in two divided doses*	AM / PM	PO			**On days 29 to 33** *Available as 0.5mg and 2mg tablets only – round to nearest 0.5mg. Take with or after food.*				

Supportive medications:

DRUG	DOSE	ROUTE	Quantity to supply	Tick of required
Aciclovir	400mg BD	PO	2 x 56	
Co-trimoxazole	……..mg BD on sat/sun See page 5	PO	28 x 480mg	
Lansoprazole	30mg OD on days 29-33	PO	1 x 28	
Metoclopramide	10mg TDS PRN	PO	1 x 28 x 10mg	
Imatinib (ABL-class fusion)	400mg – 600mg OD	PO	Month's supply	

Prescriber Sig. …… Date: …… Chemo Nurse Sig. …… Date: …… Pharmacist Sig. …… Date: ……

Patient label:

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Regimen A Maintenance

DAY NO. *(Please circle)* DATE	DRUG or ELECTROLYTE	CALCULATION	DOSE	I.V. FLUID	VOLUME (ml)	FLOW RATE	SPECIAL DIRECTIONS	DRUG ADMINISTRATION sig.	sig.	TIME	Pharm
Day 57	VINCRISTINE	1.5mg/m^2	(max 2mg)	N/Saline	50	IV 10min	(max 2mg)				(max 2mg)
	METHOTREXATE	20mg/m^2		PO			ONCE a WEEK for 4 weeks *Available as 2.5mg tablets only - round to nearest 2.5mg*				
	MERCAPTOPURINE	75mg/m^2		PO			ONCE a Day for 4 weeks *Available as 50mg tablets only - round to nearest 50mg.* Take at least 1 hour after evening meal without milk products				
	DEXAMETHASONE	6mg/m^2/day *in two divided doses*	AM PM	PO			On days 57 to 61 *Available as 0.5mg and 2mg tablets only – round to nearest 0.5mg. Take with or after food.*				

Supportive medications:

DRUG	DOSE	ROUTE	Quantity to supply	Tick of required
Aciclovir	400mg BD	PO	2 x 56	
Co-trimoxazole	……..mg BD on sat/sun See page 5	PO	28 x 480mg	
Lansoprazole	30mg OD on days 57-61	PO	1 x 28	
Metoclopramide	10mg TDS PRN	PO	1 x 28 x 10mg	
Imatinib (ABL-class fusion)	400mg – 600mg OD	PO	Month's supply	

Prescriber Sig. …… Date: …… Chemo Nurse Sig. …… Date: …… Pharmacist Sig. …… Date: ……

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Proceed rules (as per UKALL 2011 protocol):

Drug	Neutrophils ($x10^9$/L)		Platelets($x10^9$/L)		Renal (GFR ml/min)	Check LFTs ONLY if patient jaundiced. Hepatic(bilirubin µmmol/L)	Mucositis
Methotrexate (MTX)	>0.75 ≥0.5 to ≤0.75 <0.5	100% dose 50% dose Stop treatment and restart when count is >0.75. Restart at 100%, unless counts are fluctuating. In which case start at 50% dose and titrate upwards.	>75. ≥50 to ≤75 <50	100% 50% dose Stop treatment Restart treatment when >75. Restart at 100%, unless counts are fluctuating. In which case start at 50% dose and titrate upwards.	>30 = 100% dose <30 = Omit MTX until GFR >30.	>50 omit MTX until it is <20 µmol/L, and then restart at half of the previous dose. Escalate from 50% to 75% to 100% dose at 7-14 day intervals provided hyperbilirubinaemia does not recur. **Do not modify dosage for elevated aminotransferases.**	Grade 2 mucositis of over 3 days duration, decrease MTX dose by 30%. Grade 3-4 = withhold MTX until resolved; resume at 50% of the previous dose and subsequently escalate to 75% to 100% dose at 7-14 day intervals provided grade 3-4 toxicity does not recur. Consider culturing lesions for herpes simplex if mucositis persists or recurs.
Mercaptopurine	>0.75 ≥0.5 to ≤0.75 <0.5	100% 50% Stop treatment and restart when count is >0.75. Restart at 100%, unless counts are fluctuating. In which case start at 50% dose and titrate upwards.	>75. ≥50 to ≤75 <50	100% 50% dose Stop treatment Restart treatment when >75. Restart at 100%, unless counts are fluctuating. In which case start at 50% dose and titrate upwards.	No reduction necessary	>50 µmol/L omit mercaptopurine until it is <20 µmol/L, and then restart at half of the previous dose. Escalate from 50% to 75% to 100% dose at 7-14 day intervals provided hyperbilirubinaemia does not recur. **Do not modify dosage for elevated aminotransferases.**	Grade 2 mucositis of over 3 days duration decrease mercaptopurine dose by 30%. Grade 3-4 mucositis withhold mercaptopurine until resolved; resume at 50% of the previous dose and subsequently escalate to 75% to 100% dose at 7-14 day intervals provided grade 3-4 toxicity does not recur.
Vincristine	>0.75		>75		No reduction necessary	Withhold if total bilirubin >50. **Do not alter dose for abnormal transaminases.**	No reduction necessary

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Other information

- The treatment aim is to adjust doses to maintain the neutrophil count between 0.75 - 1.5x10^9/L and the platelet count between 75 - 150x10^9/L.
- Start maintenance at 100% doses **DO NOT** give higher doses at the start of maintenance therapy, even if the patient tolerated higher doses throughout interim maintenance.

Co-trimoxazole dosing (on Sat/Sun)

Surface area	Dose
1.1-1.5m^2	480mg BD
>1.5m^2	480-960mg BD

Dose escalation

- During maintenance if the neutrophil count is >1.5x10^9/L and platelets >150x10^9/L for ≥ 8 weeks, the dose of mercaptopurine should be escalated by 25% (from 75mg/m^2/day). Otherwise keep at 100% of dose.
- If the subsequent monthly neutrophil count is >1.5x10^9/L keep mercaptopurine at the 125% dose and increase oral methotrexate by 25% to a dose of 25mg/m^2.
- If the neutrophil count >1.5x10^9/L and platelets >150x10^9/L - continue to increase the mercaptopurine and oral methotrexate dose in 25% increments, alternately, every eight weeks. There are **no maximum doses** for mercaptopurine and oral methotrexate.