

**ORDERS**

ADDRESSOGRAPH

**COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS**

**BMT MA FLUTBI HAPLO  
HAPLOIDENTICAL STEM CELL TRANSPLANT  
MYELOABLATIVE CONDITIONING with FLUDARABINE AND TBI**

(items with check boxes must be selected to be ordered)

**(Page 1 of 3)**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

 Time Processed  
 RN/LPN Initials  
 Comments

☐ Consent signed for chemotherapy

**Must be completed prior to ordering chemotherapy:** This woman of child bearing potential has been assessed for the possibility of pregnancy.

\_\_\_\_\_  
Physician's signature\_\_\_\_\_  
Printed name\_\_\_\_\_  
College ID**Chemotherapy Dosing Calculations**

Height: \_\_\_\_\_ cm

Actual Weight: \_\_\_\_\_ kg

- Height and weight to be verified by 2 RNs
- Document height and weight on Nursing Assessment Form

$$BMI(kg/m^2) = \frac{Weight(kg)}{[Height(m)]^2} \text{ OR}$$

[https://www.nhlbi.nih.gov/health/educational/lose\\_wt/BMI/bmi-m.htm](https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi-m.htm)
BMI = \_\_\_\_\_ kg/m<sup>2</sup>**Ideal Body Weight:**

Male = 50 + 0.91 (height in cm – 152.4)

Female = 45.5 + 0.91 (height in cm – 152.4)

Ideal Body Weight = \_\_\_\_\_ kg

**Adjusted Body Weight (ABW):**

ABW = Ideal Body Weight (IBW) + 0.4(Actual Body Weight – IBW)

Adjusted Body Weight = \_\_\_\_\_ kg

$$BSA(m^2) = \sqrt{\frac{Height(cm) \times Weight(kg)}{3600}}$$

BSA = \_\_\_\_\_ m<sup>2</sup>

Round all BSA calculations to 2 decimal places

Adjusted BSA = \_\_\_\_\_ m<sup>2</sup>

Use Adjusted body weight or Adjusted BSA only if Ideal Body Weight less than Actual Weight to calculate chemotherapy doses

**MONITORING:**

Urine hemastix once prior to starting cyclophosphamide, then once daily until 48 hours after the completion of cyclophosphamide. Start day +3 (date): \_\_\_\_\_

**LABORATORY:**

Day +7 (date): \_\_\_\_\_ draw TACrolimus level and repeat every Monday and Thursday.

Day +7 (date): \_\_\_\_\_ draw CMV PCR then repeat every Monday through day +100 or longer if indicated.

Day +7 (date): \_\_\_\_\_ draw EBV PCR then repeat every Monday through day+100 or longer if indicated.

 \_\_\_\_\_  
 Prescriber's Signature  
 HSCT

 \_\_\_\_\_  
 Printed Name  
 VCH.VA.PPO.XXX | Rev.APR.2023

 \_\_\_\_\_  
 College ID

**Vancouver Coastal Health**  
 VA: VGH / UBCH / GFS  
 VC: BP / Purdy / GPC

**ORDERS**

ADDRESSOGRAPH

**COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS**

**BMT MA FLUTBI HAPLO  
 HAPLOIDENTICAL STEM CELL TRANSPLANT  
 MYELOABLATIVE CONDITIONING with FLUDARABINE AND TBI**

(items with check boxes must be selected to be ordered)

**(Page 2 of 3)**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Time Processed  
 RN/LPN Initials  
 Comments

**PREMEDICATIONS:**

**Note: Avoid dexamethasone as an antiemetic from day -1 to day +5**

Starting on day -9 (date) \_\_\_\_\_ 30 minutes prior to first TBI session, give  
 aprepitant 125 mg PO daily x 1 dose, then 80mg PO daily x 2 days

Starting on day -9 (date) \_\_\_\_\_ to day -5 (date) \_\_\_\_\_ 30 minutes prior to first TBI session, give:  
 ondansetron 8 mg PO BID **\*AND\***  
 dexamethasone 8 mg PO daily

On day -4 (date) \_\_\_\_\_ to day -3 (date) \_\_\_\_\_ give:  
 Dexamethasone 8mg PO daily x 2 doses

On day +3 (date) \_\_\_\_\_ 30 minutes prior to cyclophosphamide, give  
 ondansetron 8 mg PO BID **\*AND\***  
 aprepitant 125 mg PO x 1 dose

On day +4 (date) \_\_\_\_\_ 30 minutes prior to cyclophosphamide, give  
 ondansetron 8 mg PO BID **\*AND\***  
 aprepitant 80 mg PO x 1 dose

On day +5 (date) \_\_\_\_\_ give  
 aprepitant 80 mg PO x 1 dose

**CHEMOTHERAPY:**

BCCA Code for PCIS order entry: BMTNOS

*All intensive chemotherapy and transplant chemotherapy orders require 2 physician signatures, one of whom must be an attending physician.*

Total Body Irradiation 150 cGy BID. Start day -9 (date): \_\_\_\_\_ to day -6 (date): \_\_\_\_\_.

Total Body Irradiation 150 cGy ONCE on day -5 (date): \_\_\_\_\_.

fludarabine \_\_\_\_\_ mg (\*40 mg/m<sup>2</sup>, round to nearest 5 mg) in D5W IV DAILY over 60 minutes at 10:00 (after TBI). \*Adjust dose when CrCL is 70 mL/min or less.

Start day -5 (date): \_\_\_\_\_ to day -2 (date): \_\_\_\_\_. Total of 4 doses.

\_\_\_\_\_  
 Prescriber's Signature  
 HSCT

\_\_\_\_\_  
 Printed Name  
 VCH.VA.PPO.XXX | Rev.APR.2023

\_\_\_\_\_  
 College ID



VA: VGH / UBCH / GFS  
VC: BP / Purdy / GPC

**ORDERS**

ADDRESSOGRAPH

**COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS**

**BMT MA FLUTBI HAPLO  
HAPLOIDENTICAL STEM CELL TRANSPLANT  
MYELOABLATIVE CONDITIONING with FLUDARABINE AND TBI**

(items with check boxes must be selected to be ordered)

**(Page 3 of 3)**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Time Processed  
RN/LPN Initials  
Comments

**CHEMOTHERAPY CONTINUED:**

Haploidentical stem cells to be infused on day 0 (date): \_\_\_\_\_ a minimum of 48 hours after completion of fludarabine.

**GRAFT VERSUS HOST DISEASE PROPHYLAXIS:**

BCCA Code for PCIS order entry: not covered

cyclophosphamide \_\_\_\_\_ mg (50 mg/kg, round to nearest 100 mg) in sodium chloride 0.9% IV daily over 2 hours at 10:00.

Start day +3 (date): \_\_\_\_\_ to day +4 (date): \_\_\_\_\_. Total of 2 doses.

mesna (calculated at 80% of cyclophosphamide dose) = \_\_\_\_\_ mg to be given in THREE DIVIDED DOSES of \_\_\_\_\_ mg per dose (round to nearest 10 mg) IV over 15 to 30 min TID at 10:00, 14:00, 18:00 for 4 days.

Start day+3 (date): \_\_\_\_\_ to day +6 (date): \_\_\_\_\_.

TACrolimus \_\_\_\_\_ mg (0.03 mg/kg actual body weight, round to nearest 0.1 mg) in dextrose 5% IV daily by continuous infusion over 24 hours.

Start day +5 (date): \_\_\_\_\_.

mycophenolate mofetil:

☐ If patient greater than 50 kg, give 1 g IV/PO BID

☐ If patient 50 kg or less, give 15 mg/kg = \_\_\_\_\_ mg (round to the nearest 250 mg) IV/PO BID

Start day +5 (date): \_\_\_\_\_ to day +60 (date): \_\_\_\_\_

Prescriber's Signature  
HSCT

Printed Name  
VCH.VA.PPO.XXX | Rev.APR.2023

College ID



VA: VGH / UBCH / GFS  
VC: BP / Purdy / GPC

**ORDERS**

ADDRESSOGRAPH

**COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS**

**BMT MA FLUTBI HAPLO  
HAPLOIDENTICAL STEM CELL TRANSPLANT  
MYELOABLATIVE CONDITIONING with FLUDARABINE AND TBI**

(items with check boxes must be selected to be ordered)

**(Page 3 of 3)**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**SUPPORTIVE CARE:**

ursodiol (choose ONE dosing regimen only):

- ☐ 250 mg PO BID (for weight less than 40 kg)
- ☐ 250 mg PO QAM and 500 mg PO QPM (for weight 40 kg to 70 kg)
- ☐ 500 mg PO BID (for weight greater than 70 kg)

Start day -10 (date): \_\_\_\_\_ and continue until day +90 (date): \_\_\_\_\_

micafungin 100 mg IV daily. Start day +1 (date): \_\_\_\_\_

If HSV seropositive recipient give:

- ☐ valACYclovir 500 mg PO BID \*OR\* acyclovir \_\_\_\_\_ mg (5 mg/kg, round to nearest 25 mg, use ideal body weight if patient BMI of 30 or greater) IV Q12H.

Start day +1 (date): \_\_\_\_\_

**Breakthrough nausea and vomiting anti-emetics:**

- ☐ prochlorperazine 10 mg PO Q6H PRN
- ☐ metoclopramide 10 to 20 mg PO/IV Q6H PRN
- ☐ LORazepam 1 mg PO/IV Q6H PRN

**Fever orders:** as per completed FEBRILE NEUTROPENIA – INPATIENT INITIAL MANAGEMENT (# 302) PRE-PRINTED ORDERS.

**Cell Infusion:** as per completed INFUSION of HEMATOPOIETIC PROGENITOR CELLS or THERAPEUTIC CELLS (# 503) PRE-PRINTERED ORDERS.

**NOTES TO PRESCRIBER** (Unit Clerk/Pharmacy do not process – reminders for Physician only).

\* If CrCL is 70 mL/min or lower decrease fludarabine dose by 20%.

If HBsAg or Anti-HBc positive start lamivudine 100 mg PO DAILY (complete Special Authority Form) and continue for 6 months post-transplant.

PJP prophylaxis should be started by day+28 and continue until at least 12 months post transplant or longer if patient continues immunosuppressive drug

Continue VZV prophylaxis until at least 12 months post transplant or longer if patient continues immunosuppressive drugs.

Check IgG levels at day +30 then monthly. If low give IVIG 0.4 g/kg/month.

Physician to initiate Special Authority Request for mycophenolate mofetil.

Avoid all immunosuppressive medications from day -1 to day +5.

Time Processed  
RN/LPN Initials  
Comments

Prescriber's Signature  
HSCT

Printed Name  
VCH.VA.PPO.XXX | Rev.APR.2023

College ID