

ORDERS

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

BMT 04-01: RELATED MATCHED DONOR REDUCED-INTENSITY STEM CELL TRANSPLANTATION (FLUDARABINE + BUSULFAN IV)

(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

BMI = _____ kg/m²

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

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

Round all BSA calculations to 2 decimal places

BSA = _____ m²

Adjusted BSA = _____ m²

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

LABORATORY:

Day 0 (date): _____ draw cyclosporine level and repeat every Monday and Thursday.

Day +1 (date): _____, day+3 (date): _____ day +6 (date): _____ draw serum creatinine and bilirubin level in AM for methotrexate dosing

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

Prescriber's Signature
BMT 04-01

Printed Name
VCH.VA.PPO.592 | Rev.JUL.2022

College ID

**Vancouver
CoastalHealth**
VA: VGH / UBC / GFS
VC: BP / Purdy / GPC

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MEDICATIONS:**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.

fludarabine _____ mg (30 mg/m², round to nearest 5 mg) IV in D5W DAILY over 30 minutes at 09:00.

Start day -8 (date) _____ to day -4 (date) _____. Total of 5 doses.

busulfan _____ mg (3.2 mg/kg, round to nearest 5 mg) IV in NS DAILY over 3 hours at 10:00.

Give day -3 (date): _____ and day -2 (date): _____. Total of 2 doses.

LORazepam 1 mg PO/SL/IV Q6H (at 09:00, 15:00, 21:00, 03:00) for seizure prophylaxis. Start at 09:00.

Start day -3 (date): _____ to day -1 (date): _____.

Graft versus Host Disease Prophylaxis:

BCCA Code for PCIS order entry: NOT COVERED

cycloSPORINE _____ mg (3 mg/kg actual body weight, round to nearest 5 mg) in D5W 250 mL continuous IV infusion over 24 hours DAILY.

Start on day -2 (date): _____.

methotrexate _____ mg (5 mg/m², round to nearest 1 mg) IV over 20 minutes on the following dates:

day +1 (date): _____, day +3 (date): _____, and day +6 (date): _____.

Administer first dose at least 24 hours after hematopoietic progenitor infusion.

Check with physician prior to each dose.

Hematopoietic progenitor cells to be infused on day 0 (date): _____.

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SUPPORTIVE CARE:

ursodiol (choose ONE dosing regimen only):

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

Start day -9 (date): _____ and continue until day +90 (date): _____

allopurinol 300 mg PO DAILY X 10 days for all patients not in remission at time of hematopoietic progenitor cell infusion.

Start day -9 (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): _____

Antiemetics: as per completed ANTIEMETIC REGIMEN-LEUKEMIA/BMT (#412) PRE-PRINTED orders.

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 Orders.

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

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

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

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

Refer to L/BMT manual for methotrexate dosing guidelines.

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