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

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

BMT RIC FLUTREOATG
RELATED OR UNRELATED DONOR ALLOGENEIC STEM CELL TRANSPLANT
REDUCED INTENSITY CONDITIONING with FLUDARABINE, TREOSULFAN and ANTI-THYMOCYTE GLOBULIN

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

Time Processed
RN/LPN Initials
Comments

Date: _____ **Time:** _____

☐ **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.

_____ _____ _____
Prescriber's signature Printed name College ID

Chemotherapy Dosing Calculations	
Height: _____ **cm**	**Actual Weight:** _____ **kg**
▪ Document height and weight on Nursing Assessment Form and must be co-signed by 2 RNs	
$BMI(kg/m^2) = \frac{Weight(kg)}{[Height(m)]^2}$ **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

MONITORING:

During each anti-thymocyte globulin rabbit infusion: Monitor vital signs Q15MIN x 4; then Q30MIN x 4; then Q4H.

LABORATORY:

Day 0 (date):_____ draw cycloSPORINE trough level at 05:30 and repeat every Monday and Thursday.

Day +1 (date): _____, day+3 (date):____day +6 (date):_____draw serum creatinine and bilirubin (total and direct) level in AM for methotrexate dosing.

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.

_____ _____ _____
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Time Processed RN/LPN Initials Comments

Date: _____ **Time:** _____

☐ **Health Canada Special Access Program (SAP) approval obtained for treosulfan (date):**_____

∗ **AND**∗ **BC Cancer CAP Approval obtained for * treosulfan (SAP) (date):**_____

CHEMOTHERAPY:

BCCA Code for PCIS order entry: _____ (as per Compassionate Program designation)

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

fludarabine _____mg (30 mg/m^2 , round to nearest 5 mg) in dextrose 5% (D5W) IV daily over 30 minutes at 09:00. Adjust dose when CrCl is 70 mL/min or less. Refer to Notes to Prescriber.

Start day -6 (date) _____ to day –2 (date) _____. Total of 5 doses.

treosulfan _____ g (12 g/m^2, round to nearest 0.1 g) IV daily over 2 hours at 10:00.

Start day –6 (date):_____ to day –4(date):_____. Total of 3 doses.

antithymocyte globulin rabbit (THYMOGLOBULIN) _____ mg (1.5 mg/kg, actual body weight, round to nearest 5 mg) IV daily at 10:00.

Start day –3 (date) _____to day -1 (date)_____. Total of 3 doses.

Premedications for each antithymocyte globulin rabbit infusion:
diphenhydrAMINE 50 mg PO x 1 dose one hour prior to, and Q4H during the infusion
acetaminophen 650 mg PO x 1 dose once hour prior to, and Q4H during the infusion
hydrocortisone 100 mg IV x 1 dose one hour prior

Infuse antithymocyte globulin rabbit through an in-line 0.2 micron filter. Initial dose (day -3) to be infused over 8 to 12 hours (up to 24 hours). If no reaction, subsequent doses can be infused over a minimum of 4 hours. **Confirm with Pharmacy before each dose.**

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

_____ Prescriber's Signature

_____ Printed Name

_____ College ID

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Time Processed
RN/LPN Initials
Comments

Date: _____ **Time:** _____

Graft versus Host Disease Prophylaxis:
BCCA Code for PCIS order entry: not covered

cycloSPORINE _____ mg (1.5 mg/kg, use actual weight, round dose to nearest 5 mg) in dextrose 5% (D5W) IV Q12H at 06:00 and 18:00. Infuse over 4 hours. Start at 18:00 on Day -2 (date) _____

methotrexate _____mg (5 mg/m^2, 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 prescriber prior to each dose.

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 –7 (date):_____ and continue until day +90 (date): _____

allopurinol 300 mg PO daily for 10 days for all patients NOT in remission at time of hematopoietic progenitor cell infusion. Start day –7 (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 is 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 (# 503) PRE-PRINTERED ORDERS.

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

If CrCl is 70 mL/min or lower, decrease fludarabine dose by 20%. Reassess need for dose adjustment daily.

If HBsAg or Anti-HBc positive start lamivudine 100 mg PO daily (complete Special Authority Form) and continue until at least 12 months post-transplant or longer if patient continues immunosuppressive drugs.

PJP 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.

_____ Prescriber's Signature

_____ Printed Name

_____ College ID