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

ORDERS

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

BMT CART TISALY
TISAGENLECLEUCEL FOR AGGRESSIVE B-CELL LYMPHOMA - OUTPATIENT
LYMPHODEPLETING CHEMOTHERAPY ORDERS WITH CYCLOPHOSPHAMIDE AND FLUDARABINE

(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 patient of child bearing potential has been assessed for the possibility of pregnancy.

_____ _____ _____
Prescriber 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	
$BMI(kg/m^2) = \frac{Weight(kg)}{[Height(m)]^2}$ https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi-m.htm	**BMI = _____ kg/ m²**
$BSA(m^2) = \sqrt{\frac{Height(cm) \times Weight(kg)}{3600}}$ Round all BSA calculations to 2 decimal places	**BSA = _____ m²**

Use actual weight or BSA to calculate chemotherapy doses

LABORATORY:

On Days -5, -4, and -3:
CBC with differential
Sodium, potassium, urea, creatinine, alkaline phosphatase, total and direct bilirubin, GGT, ALT, LDH, albumin

On Day -5:
CRP, ferritin, immunoglobulins, PTT, INR, random glucose, calcium, phosphate, magnesium, uric acid

MONITORING:

On Days --5, -4, and -3:
Vital signs

Day -5:
Weight

INTRAVENOUS: sodium chloride 0.9% IV 1000 mL over 2 hours PRIOR to EACH cyclophosphamide infusion
sodium chloride 0.9% IV 1000 mL over 2 hours AFTER EACH fludarabine infusion

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PREMEDICATIONS:

Starting on day -5 (date) _____ to day -3 (date) _____ 30 minutes prior to chemotherapy, give:

ondansetron 8 mg PO 30 minutes prior to the first dose of chemotherapy

CHEMOTHERAPY:

BCCA Code for order entry: ###

One staff physician's signature is required. For other providers, please obtain a co-signature from a staff physician.

Do not initiate chemotherapy until you have confirmation from physician to proceed

cyclophosphamide_____ mg (250 mg/m^2) IV over 60 minutes daily for 3 days

Give on: Day -5 (date) _____, Day -4 (date) _____ and Day -3 (date) _____

fludarabine _____ mg (25 mg/m^2)) IV over 30 minutes daily for 3 days.

*Adjust dose when CrCL is 80 mL/min or less. Refer to Notes to Prescriber

Give on: Day -5 (date) _____, Day -4 (date) _____ and Day -3 (date) _____

Patient to be admitted Day -1 for tisagenlecleucel cell product infusion on Day 0 (date): _____ at least 48 hours after the last dose of fludarabine

SUPPORTIVE CARE:

Provide Out-patient prescription for the following:

ondansetron 8 mg PO to be taken ONCE daily in the evening on chemotherapy days, then may take 8 mg PO BID PRN

Mitte: 10 doses

allopurinol 300 mg PO BID x 4 doses starting on the first day of chemotherapy, then 300 mg PO daily x 3 days

Mitte: 7 doses

Antiemetics for breakthrough nausea and vomiting:

- ☐ prochlorperazine 10 mg PO ONCE PRN (do not give concurrently with metoclopramide)
- ☐ metoclopramide 10 to 20 mg PO or IV ONCE PRN (do not give concurrently with prochlorperazine)
- ☐ LORazepam 1 mg PO or IV ONCE PRN

Fever orders: as per completed BMT FEBRILE NEUTROPENIA INITIAL MANAGEMENT PLAN
CAR-T cell orders: as per BMT CAR-T Cell Infusions Orders (inpatient)

_____ Prescriber's Signature

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

Fludarabine dosage adjustments:

CrCl (mL/min) *(Calculated using Cockcroft –Gault formula)*	
Greater than or equal to 80	No adjustment
50 to 79	80% dose (20% dose reduction)
30 to 49	60% dose (40% dose reduction)
Less than 30	Not recommended (exclusion criteria)

Do NOT give corticosteroid therapy at pharmacologic doses (greater than or equal to 20 mg/day of prednisone or equivalent doses of other corticosteroids) and other immunosuppressive drugs starting Day -5 _____ (date). Avoid for 3 months unless used to manage CAR-T related toxicities

Ensure patient is added to the inpatient admission list for evening of Day -1 _____ (date)

_____ _____ _____
Prescriber's Signature Printed Name College ID