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

ORDERS

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

MELPHALAN CHEMOTHERAPY ORDERS (BMTMM0301)
OUTPATIENT AUTOGRAFT FOR MULTIPLE MYELOMA

(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

FAX the completed conditioning chemo PPO to Data Coordinator's Office at 604-675-3782

MONITORING: Vital signs with each visit
Weight once weekly
If temperature greater than 38°C, notify Hematology Associate/Fellow for initiation of antibiotics
Nurse to confirm COVID-19 test negative prior to requesting melphalan from pharmacy

LABORATORY: On day -1 and each visit:
CBC with differential, electrolytes, urea, creatinine
On day -1 (if not previously done within 96 hours of day -1):
serum protein electrophoresis, quantitative immunoglobulins, serum free light chain
On day -1 and weekly:
INR, magnesium, calcium, phosphate, albumin
Bilirubin (total & direct), alkaline phosphatase, LDH, AST, ALT

SUPPORTIVE CARE: No enemas, suppositories, IM injections
No ASA or non-steroidal anti-inflammatory drugs (NSAIDs)

PREMEDICATIONS: aprepitant 125 mg PO 30 minutes prior to chemotherapy
ondansetron 8 mg PO 30 minutes prior to chemotherapy
dexamethasone 12 mg PO 30 minutes prior to chemotherapy
For anticipatory nausea: ☐ LORazepam _____ mg sublingual 30 minutes prior to chemotherapy

INTRAVENOUS: sodium chloride 0.9% 1 L IV at 250 mL/hour for 2 hours pre-melphalan and for 2 hours post-melphalan infusion. Hold IV fluid during melphalan infusion.

Starting day +2 (date) _____ give IV fluids each visit as follows:

☐ potassium chloride 40 mmol and magnesium sulphate 2 g in sodium chloride 0.9% 1 L IV over 2 hours

☐ potassium chloride 20 mmol in sodium chloride 0.9% 1 L IV over 1 hour

_____ _____ _____
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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

CHEMOTHERAPY:

- BCCA Code for PCIS order entry: BMTMM0301

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

melphalan (check one)

melphalan dose	Creatinine Clearance (mL/min)
☐ 200 mg/m²	50 or greater
☐ 140 mg/m²	Less than 50

(rounded to the nearest 5 mg) _____ mg IV in sodium chloride 0.9%**

Start on day –1 (date): _____

**Due to short stability, each bag of melphalan must be administered over 30 to 60 minutes. Pharmacy will determine the bag volume as melphalan concentration must be between 0.1 to 0.45 mg/mL. Doses greater than 250 mg will be divided into TWO bags based upon concentration. Contact Pharmacy at local 63587 when the first bag is started so the second bag can be prepared.

Stem cell product to be infused on day 0 (date): _____at least 24 hours after completion of melphalan. Hold IV hydration on day of stem cell product infusion.

_____ _____ _____
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Date: _____ **Time:** _____

SUPPORT MEDICATIONS:

metoclopramide 10 mg PO or IV Q6H PRN ✳**OR**✳ prochlorperazine 10 mg PO Q6H PRN for breakthrough nausea

☐ LORazepam 0.5 to 1 mg sublingual or PO Q6H PRN for breakthrough nausea

☐ ondansetron 8 mg IV or PO Q8H PRN for breakthrough nausea

☐ diphenhydrAMINE 25 mg PO or IV Q6H PRN for treatment of dystonic reaction, restlessness or muscle stiffness or hypersensitivity reaction to blood products

☐ lidocaine viscous 2% 5 mL and ALMAGEL PLUS EQUIV 10 mL, mixed, swish and swallow Q4H PRN mucositis pain. Instruct patient not to eat or drink for 30 minutes after use.

☐ codeine 15 mg PO Q4H PRN ✳**OR**✳ Other: _____ for mucositis pain

☐ alteplase 2 mg/2 mL per occluded lumen PRN. Dwell for 1 hour. May repeat x 1.

For all patients, provide prescription for the following medications:

aprepitant 80 mg PO daily x 2 days. Start on day 0 (date): _____

dexamethasone 8 mg PO daily x 4 days. Start on day 0 (date): _____

ondansetron 8 mg PO x 1 dose in the evening of day -1 (date) _____, then 8 mg PO BID PRN breakthrough nausea and vomiting

ciprofloxacin 500 mg PO BID x 10 days. Start day + 3 (date): _____

fluconazole 400 mg PO daily x 14 days. Start day + 3 (date): _____

chlorhexidine 0.12% mouth wash 15 mL swish and spit BID

valACYclovir 500 mg PO BID. Start day -1 (date): _____

If not on acid suppressive therapy, give ☐ pantoprazole 40 mg PO daily x 14 days

RETURN APPOINTMENTS:

Book appointments for chemotherapy administration and stem cell product infusion

Book appointment for blood work and possible transfusion ☐ every day ✳**OR**✳ ☐ every 2 days (check one) after completion of stem cell product infusion for _____ weeks.

NOTES TO PRESCRIBER (Unit Clerk/Pharmacy do not process – reminders for Prescriber only)
If HBsAg or Anti-HBc positive, start lamiVUDine 100 mg PO daily (complete Special Authority Form) and continue for 6 months post-transplant
Continue VZV prophylaxis for 1 year post stem cell transplant

Fever orders: as per completed FEBRILE NEUTROPENIA – OUTPATIENT INITIAL MANAGEMENT (# 310) Pre-Printed Orders

Stem cell product orders: as per completed INFUSION OF HEMATOPOIETIC PROGENITOR CELLS (MARROW, APHERESIS OR CORD) OR THERAPEUTIC CELLS (T-CELLS) (# 503) Pre-Printed Orders

_____ _____ _____
Prescriber's Signature | Printed Name | College ID