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

ORDERS

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

ACUTE LYMPHOBLASTIC LEUKEMIA (ALL 13-01)
CONTINUATION CHEMOTHERAPY ORDERS – OUTPATIENT
Adult Ph-Negative ALL Patients (16-39 years)

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

Use actual weight or BSA to calculate chemotherapy doses

Starting Criteria

Absolute neutrophil count (ANC) 1.0 x 10^9/ L or greater, platelets 100 x 10^9/ L or greater, direct bilirubin 23.9 micromol/L or less, AST 8 times or less of upper limit of normal (ULN), mucositis none or mild.
Start after completion of ALL 13-01 Consolidation II phases of therapy.

LABORATORY:

CBC with differential, INR, bilirubin (total and direct), ALT, AST, LDH, SCr, BUN, electrolytes on Day 1 and each visit

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CYCLE #: _____

MEDICATIONS:

BCCA Code for PCIS order entry: LKNOS
All intensive chemotherapy orders require 2 prescriber signatures, one of whom must be an attending physician.

Chemotherapy Intrathecal injection: (Use preservative-free solutions only)

methotrexate 12 mg plus cytarabine 40 mg plus hydrocortisone 50 mg IT every 18 weeks until 2 years of continued complete remission. See completed ALL 13-01 INTRATHECAL CHEMOTHERAPY (FOR CONSOLIDATION II & CONTINUATION) (#858) PRE-PRINTED ORDERS.

Chemotherapy:

vinCRIStine (1.4 mg/m^2 rounded to the nearest 0.1 mg to a maximum of 2 mg) _____mg IV in dextrose 5% (D5W) 50 mL over 15 to 30 minutes on Day 1 (date): _____

☐ vinCRIStine dose modification: _____ % reduction = _____ mg IV on Day 1

Dose modification for: ☐ Hepatotoxicity ☐ Other toxicity _____

Confirm each vinCRIStine dose with prescriber prior to administration.

Provide prescriptions for the following to be picked up from BC Cancer Outpatient Pharmacy:

dexamethasone (3 mg/m^2/dose rounded to nearest 2 mg) _____ mg PO BID x 5 days

Start on Day 1 (date): _____ and stop after last dose on Day 5 (date):_____

methotrexate (30 mg/ m^2 rounded to nearest 2.5 mg) _____mg PO once weekly

☐ methotrexate dose modification: _____ % reduction = _____ mg PO once weekly

Dose modification for: ☐ Cytopenias ☐ Hepatotoxicity ☐ Other toxicity _____

Give on Day 1 (date): _____ , Day 8 (date):_____, Day 15 (date):_____

HOLD systemic methotrexate on the day INTRATHECAL methotrexate is given

mercaptopurine (50 mg/m^2/dose; rounded to nearest 25 mg) _____ mg PO QHS x 14 days

☐ mercaptopurine dose modification: _____ % reduction = _____ mg PO QHS x 14 days

Dose modification for: ☐ Cytopenias ☐ Hepatotoxicity ☐ Other toxicity _____

Start on Day 1 (date): _____ and stop after last dose on Day 14 (date): _____

No food or milk 1 hour prior to and 2 hours after administration

Fever orders: as per completed FEBRILE NEUTROPENIA – OUTPATIENT INITIAL MANAGEMENT (#310) PREPRINTED orders

Book patient with primary BMT physician every 3 months; Primary BMT physician (name): _____
Next appointment is booked on (date): _____

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NOTES TO PRESCRIBER: (Unit Clerk/Pharmacy do not process – reminders to prescriber only)
Repeat this 3-week sequence of treatment until 2 years after complete remission

PJP prophylaxis is required until the completion of all treatment.
For hepatitis B prophylaxis, continue lamiVUDine and refer to the L/BMT Manual for recommended duration of therapy and frequency of hepatitis B DNA level monitoring.
vinCRIStine: Concomitant use of vinCRIStine and voriconazole or posacaconazole or other azole antifungal agents EXCEPT fluconazole is contraindicated.
vinCRIStine to be administered through a central line.

vinCRIStine Dose Modifications:

- Dose may be delayed and/or reduced for peripheral neuropathy, ileus, SIADH, hyperbilirubinemia, or life-threatening illness, but should be resumed at full dose as soon as possible.
- If direct bilirubin is below 23.9 micromol/L, give full dose; If direct bilirubin is 23.9 micromol/L or higher but less than 51.3 micromol/L, give 50% of vinCRIStine; If direct bilirubin is 51.3 micromol/L or higher; Hold vinCRIStine.

Oral methotrexate and mercaptopurine Dose Modifications for Cytopenias (ANC and platelet units are x 10^9/L):

- If ANC below 0.5 or platelets below 75 at any point, hold methotrexate ***AND*** mercaptopurine until recovery above these thresholds. Identify and resolve alternate causes of cytopenias. Resume both at full doses once ANC above 0.75 and platelets above 75.
- If ANC below 0.5 or platelets below 75 a second time, hold methotrexate ***AND*** mercaptopurine until ANC above 0.75 and platelets above 75. On the same day the counts recover, resume methotrexate ***AND*** mercaptopurine. Dose reduce either methotrexate ***OR*** mercaptopurine by 50% of the original dose. Do not make up missed doses.
- If ANC below 0.5 or platelets below 75 at reduced doses of methotrexate ***OR*** mercaptopurine, hold methotrexate ***AND*** mercaptopurine until ANC above 0.75 and platelets above 75. On the same day the counts recover, restart mercaptopurine ***AND*** methotrexate with both drugs reduced by 50% of the original doses. Do not make up missed doses.
- Re-escalate doses to 75% and then 100% of the original dose in 3 to 6 week intervals on Day 1 of subsequent cycles, provided counts remain above threshold (ANC above 0.75 and platelets above 75). If both methotrexate ***AND*** mercaptopurine are dose reduced, re-escalate sequentially.
- Consider need for thiopurine S-methyltransferase (TPMT) genotype testing in case of recurrent cytopenias attributed to mercaptopurine.

Oral methotrexate and mercaptopurine Dose Modifications for Hepatotoxicity:

- Hold methotrexate ***AND*** mercaptopurine if AST above 8 x ULN or direct bilirubin 24 micromol/L or above during the cycle. Identify and resolve alternate causes of hepatotoxicity.
- On the same day AST and bilirubin fall below thresholds, resume methotrexate ***AND*** mercaptopurine. Dose reduce either mercaptopurine ***OR*** methotrexate by 20% of the original dose. Do not make up missed doses.
- If AST above 8 x ULN or direct bilirubin 24 micromol/L or above on a reduced dose of methotrexate ***OR*** mercaptopurine, hold both drugs until AST and bilirubin have fallen below these thresholds. Resume methotrexate ***AND*** mercaptopurine with both drugs reduced by 20% of their original doses. Do not make up missed doses.
- Alternate 20% reductions of methotrexate ***AND*** mercaptopurine in the case of recurrent elevation of AST or bilirubin above thresholds.
- Consider stepwise re-escalation of chemotherapy to standard doses if AST and bilirubin remain in the normal range on dose reduced chemotherapy after 1 or more cycles. If both methotrexate ***AND*** mercaptopurine are dose reduced, re-escalate sequentially.

Prescriber's Signature | Printed Name | College ID