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)
CONSOLIDATION IA (HiDMTX) CHEMOTHERAPY ORDERS - INPATIENT

Adult Ph-Negative ALL Patients (16-40)

(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 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/losewt/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

Patient is in complete remission at all sites, APC is 1 or greater, platelets are 100 x 10^9/ L or greater, direct bilirubin is 23.9 micromol/L or less, AST is 8 times or less of the upper limit of normal, creatinine is 115 micromol/L or less, no mucositis, no ascites or effusions or significant edema

INTRAVENOUS:

discontinue all other IV fluids

sodium bicarbonate 100 mmol in dextrose 5% (D5W) 1000 mL continuous IV infusion at 250 mL/hour
Start on Day 1 (date): _____ at _____ (time) at least 6 hours prior to methotrexate infusion,
Fluid volume may be adjusted to maintain dilute urine (specific gravity of 1.01 or less)
Amount of sodium bicarbonate may be adjusted to maintain urine pH 7 or greater
Continue infusion until methotrexate level is less than 0.1micromol/L.

Ensure total fluids are at least 200 mL/hour if:
- methotrexate level is greater than 100 micromol/L at the end of infusion (hour 24)
- methotrexate level is greater than 0.18 micromol/L at hour 48
- methotrexate level is greater than 0.1 micromol/L at hour 72

LABORATORY:

Urine pH before starting methotrexate.
If pH is less than 7, repeat urine pH with each void until pH is greater than 7 before starting methotrexate.
Then urine pH every 6 hours during methotrexate infusion and until leucovorin rescue is completed.
If urine pH is less than 7 at any time, notify prescriber.

_____ _____ _____
Prescriber's Signature Printed Name College ID

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LABORATORY cont.:

Bilirubin (total & direct) on Day 1
methotrexate Levels
If 24 hour methotrexate level is 100 micromol/L or less, check level every 24 hours until methotrexate level is less than 0.1 micromol/L
If 24 hour methotrexate level is greater than 100 micromol/L check level every 12 hours until methotrexate level is less than 5 micromol/L then every 24 hours until methotrexate level is less than 0.1 micromol/L
(See page 3 of this order for methotrexate levels and leucovorin rescue doses)

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 hydrocortisone 50 mg IT on Day 1 (date) _____ at _____(time) as per completed INTRATHECAL CHEMOTHERAPY (#819) PRE-PRINTED orders

(Note: Induction Day 29 IT methotrexate can be considered to be Day 1 Consolidation I IT methotrexate if given within 72 hours of beginning Consolidation IA systemic therapy)

Chemotherapy:

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

DOXOrubicin (30 mg/m^2 rounded to nearest 5 mg) _____mg in dextrose 5% (D5W) 50 mL IV over 10 to 20 min x 1 dose on Day 1 (date): _____ at 08:00
Cumulative DOXOrubicin dose administered including this cycle: _____ mg/m^2

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

APC: Absolute polymorph count = sum (neutrophils + monocytes + bands)

vinCRIStine: Verify each dose with prescriber prior to administration. Concomitant use of vinCRIStine and voriconazole or posacaconazole or other azole antifungal agents EXCEPT fluCONazole is contraindicated.

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

Dose modifications for DOXOrubicin: Direct bilirubin must be 23.9 micromol/L or lower before DOXOrubicin is given

DOXOrubicin and vinCRIStine to be administered through a central line

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Date: _____ **Time:** _____

Chemotherapy cont.:

methotrexate (5 g/m^2 rounded to nearest 0.1 g) _____ grams IV over 24 hours on Day 1 (date) _____ at _____(time)

Start infusion at least 8 hours but no more than 24 hours after last DOXOrubicin dose
Start infusion when urine specific gravity is 1.01 or less and pH is 7 or greater
Record the time at which the methotrexate infusion starts: _____. This is time zero.

Penicillins, proton pump inhibitors, cotrimoxazole can significantly reduce the renal clearance of high dose methotrexate. Avoid concomitant use of these medications until the methotrexate level is below 0.1 micromol/L

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

Start on Day 1 (date): _____ and stop after the last dose on Day 14 (date): _____
No food or milk 1 hour prior to and 2 hours after administration

Support Medications: See below for 24, 48 and 72 hr leucovorin dosing

If HSV seropositive, give: ☐ valACYclovir 500 mg PO BID. Start Day 5 (date): _____

fluconazole 400 mg PO daily. Start Day 5 (date): _____

Hold cotrimoxazole (SEPTRA EQUIV) until methotrexate level is less than 0.1 micromol/L then restart; prescriber to write new order

Antiemetic orders – as per completed ANTIEMETIC PROTOCOL LEUKEMIA-BMT PROGRAM (#412) PRE-PRINTED orders

Fever orders – as per completed FEBRILE NEUTROPENIA –INPATIENT INITIAL MANAGEMENT (#302) PRE-PRINTED orders

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Leucovorin Rescue Orders Based on methotrexate Levels:

24 hour level (at completion of methotrexate infusion):

If methotrexate level is 100 micromol/L or less:

leucovorin (75 mg/m^2) _____mg IV x 1 bolus dose; give 36 hours after the start of methotrexate infusion then
leucovorin (15 mg/m^2) _____mg IV Q6H; start 6 hours after the leucovorin bolus dose and continue until methotrexate level is less than 0.1 micromol/L

If methotrexate level is greater than 100 micromol/L immediately start:

leucovorin (100 mg/m^2) _____mg IV Q3H until level is less than 5 micromol/L then
leucovorin (15 mg/ m^2) _____mg IV Q3H when level is less than 5 micromol/L until methotrexate level is less than 0.1 micromol/L

NOTES TO PRESCRIBER: (Unit Clerk/Pharmacy do not process – reminders to prescribers only)
Leucovorin Rescue Dosing: PRESCRIBER TO WRITE NEW LEUCOVORIN ORDERS BASED ON METHOTREXATE LEVELS

48 hour level: (from the end of the methotrexate infusion)

if methotrexate level is greater than 0.1 but less than 5 micromol/L give:
leucovorin (15 mg/m^2) IV Q6H until methotrexate level less than 0.1 micromol/L
if methotrexate level is greater than 5 micromol/L give:
leucovorin (15 mg/m^2) IV Q3H until methotrexate level less than 0.1 micromol/L

72 hour level: (from the end of the methotrexate infusion)

if methotrexate level is greater than 0.1 but less than 5 micromol/L give:
leucovorin (15 mg/m^2) IV Q6H until methotrexate level less than 0.1 micromol/L
if methotrexate level is greater than 5 micromol/L give:
leucovorin (15 mg/m^2) IV Q3H until methotrexate level less than 0.1 micromol/L

**When methotrexate level is less than 0.1 micromol/L discontinue leucovorin and restart PJP prophylaxis **

_____ Prescriber's Signature
_____ Printed Name
_____ College ID