MemorialCare

MHS Beacon Adult Chemotherapy Order Form

Patient Name: _____ **MRN #:** _____ **DOB:** _____ **Age:** _____

Diagnosis: _____ **Height:** _____ **Weight:** _____ **BSA:** _____ **Allergies:** _____

Chemotherapy Treatment Regimen/Protocol: _____

Chemotherapy Treatment Start Date: _____ **Current Cycle #:** _____ **Day #:** _____ **Total # of Cycles Planned:** _____

Line Care Therapy Plan: *(All medications will be ordered together. For IV patency - amount needed for different lines will be determined per hospital policy.)*

- [x] • heparin PF 100 unit/mL lock flush 300 units (3 mL) IV PRN Conditional IV Line Maintenance/Care
- [ ] • heparin PF 100 unit/mL lock flush 500 units (5 mL) IV PRN Conditional IV Line Maintenance/Care
- [ ] • saline lock flush 10 mL IV PRN Conditional IV Line Maintenance/Care
- [ ] • saline lock flush 20 mL IV PRN Conditional IV Line Maintenance/Care
- [ ] • NS 250 mL at 20 mL/hr (TKO) IV Infusion PRN Continuous IV Line Maintenance/Care
- [ ] • D5W 250 mL at 20 mL/hr (TKO) IV Infusion PRN Continuous IV Line Maintenance/Care [To be used with drugs incompatible with NS]

Treatment Conditions:

- [ ] Notify Provider and hold chemotherapy if ANC is less than _____ and/or platelets are less than _____
- [ ] Notify Provider if: _____

Labs: [ ] Draw on Cycle # ____ Day # ____ [ ] Prior to chemotherapy [ ] Daily x ____ days [ ] Every Other Day
[ ] CBC w/diff [ ] CMP [ ] Mg [ ] Phos [ ] SCr [ ] LDH [ ] uric acid [ ] urine pH
[ ] Other _____

Continuous Maintenance IV Fluids (for inpatient use): (*If new IVF is ordered for chemotherapy regimen, all currently active IVF orders would be discontinued.*)

[ ] None [ ] NS 1000 mL IV at _____ mL/hr [ ] ½ NS 1000 mL IV at _____ mL/hr
[ ] D5 NS 1000 mL IV at _____ mL/hr [ ] D5 ½ NS 1000 mL IV at _____ mL/hr [ ] Other: _____

Pre-Chemotherapy IV Hydration:

[ ] None [ ] NS 250 mL IV over 30 mins [ ] NS 500 mL IV over 60 mins [ ] Other: _____

Post-Chemotherapy IV Hydration:

[ ] None [ ] NS 250 mL IV over 30 mins [ ] NS 500 mL IV over 60 mins [ ] Other: _____

Antiemetics: (*Administer 30 minutes prior to chemotherapy or follow administration instructions.*)

[ ] High Emetic Risk (Day 1)

- Fosaprepitant (Emend) 150 mg IV Once
- Dexamethasone (Decadron) 12 mg IV Once
- OLANZapine (Zyprexa) 5 mg PO Once
- 5-HT3 antagonist (choose one):
  - [ ] Palonosetron (Aloxi) 0.25 mg IV Once
  - [ ] Ondansetron (Zofran) 8 mg IV Once
  - [ ] Granisetron (Kytril) 1 mg IV Once

[ ] High Emetic Risk (Day 2 to _____ for Multiday Chemo)

- Dexamethasone (Decadron) 12 mg IV Once
- OLANZapine (Zyprexa) 5 mg PO Once
- 5-HT3 antagonist (choose one if Palonosetron not given on Day 1):
  - [ ] Ondansetron (Zofran) 8 mg IV Once
  - [ ] Granisetron (Kytril) 1 mg IV Once

[ ] Continue Dexamethasone 8 mg IV daily x 3 days after end of chemo
[ ] Continue OLANZapine 5 mg PO nightly x 3 days after end of chemo

[ ] Moderate Emetic Risk (Day 1)

- Dexamethasone (Decadron) 12 mg IV Once
- 5-HT3 antagonist (choose one):
  - [ ] Palonosetron (Aloxi) 0.25 mg IV Once
  - [ ] Ondansetron (Zofran) 16 mg IV Once
  - [ ] Granisetron (Kytril) 1 mg IV Once

[ ] Moderate Emetic Risk (Day 2 to _____ for Multiday Chemo)

- Dexamethasone (Decadron) 12 mg IV Once
- 5-HT3 antagonist (choose one if Palonosetron not given on Day 1):
  - [ ] Ondansetron (Zofran) 16 mg IV Once
  - [ ] Granisetron (Kytril) 1 mg IV Once

[ ] Continue Dexamethasone 8 mg IV daily x 2 days after end of chemo
[ ] No further scheduled therapy is required (if Palonosetron is given on Day 1)

MD Name (Printed) _____ **MD Signature** _____ **Date / Time** _____

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☐ **Low Emetic Risk (Day 1)**
- Choose one:
  - ☐ Ondansetron (Zofran) __8__ mg IV Once
  - ☐ Dexamethasone (Decadron) __8__ mg IV Once

☐ **Low Emetic Risk (Day 2 to _____ for Multiday Chemo)**
- Choose one:
  - ☐ Ondansetron (Zofran) __8__ mg IV Once
  - ☐ Dexamethasone (Decadron) __8__ mg IV Once

☐ Other Antiemetics for prophylaxis of nausea/vomiting: _____

PRN Antiemetics for Breakthrough N/V:

☐ Prochlorperazine (Compazine) 10 mg IV Q6H PRN N/V
☐ Ondansetron (Zofran) 8 mg IV Q8H PRN N/V
☐ Granisetron (Kytril) 1 mg IV Q12H PRN N/V
☐ LORazepam (Ativan) __0.5__ mg __IV__ Q8H PRN anxiety, N/V
☐ DiphenhydrAMINE (Benadryl) 25 mg IV Q6H PRN itching, N/V
☐ OLANZapine (Zyprexa) __5__ mg PO daily. Start as needed for N/V
Give first dose prior to chemotherapy, then continue nightly
☐ Other: _____

Pre-Medications:

☐ DiphenhydrAMINE (Benadryl) 25 mg IV ONCE
☐ Famotidine (Pepcid) 20 mg IV ONCE
☐ Acetaminophen (Tylenol) 650 mg PO ONCE
☐ Dexamethasone (Decadron) _____ mg IV ONCE
(If dexamethasone is also ordered as an antiemetic, then extra dose will be removed)
☐ Atropine 0.4 mg SubQ ONCE prior to Irinotecan
☐ Other: _____

Chemotherapy: *(Please do not use unapproved abbreviations such as "d" for dose or Day…)*

- **Reference for protocol/regimen:** *(i.e., MHS Beacon protocol [from Protocol Preview], NCCN chemo template, guidelines, primary literature, etc.)*
  _____
- **Reason for chemotherapy dose deviation from standard protocol/regimen:**
  ☐ Age ☐ Renal Function ☐ Hepatic Function ☐ Hematologic Factors ☐ Previous Toxicity ☐ Other: _____
- **BSA dosing:** If BSA > 2 m^2, use maximum BSA of _____ m^2 OR ☐ actual BSA
- **For AUC dosing:** Patient's actual SCr will be used for dose calculation (minimum of 0.7 mg/dL per hospital policy) unless MD specifies SCr to use here: _____ mg/dL. (Maximum CrCl used for dose calculation is 125 mL/min.) If CARBOplatin is ordered, prescriber MUST calculate and specify dose in milligrams.
  Link to CARBOplatin AUC Calculator (Calvert)
- Documentation required for ***Lifetime Cumulative Dose (LCD)*** given to date: Anthracyclines _____ mg/m^2 or Bleomycin _____ units.

Drug Name	Intended Dose (mg/m^2 or mg/kg or AUC)	Actual Dose (mg or units)	Route & Frequency

MD Name (Printed) _____ **MD Signature** _____ **Date / Time** _____

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Infusion Reaction Medications: *(All medications will be ordered together; RN will notify physician of all chemo infusion reactions)*

☐
- Acetaminophen (Tylenol) 650 mg PO PRN x 1 for fever, chills
- DiphenhydrAMINE (Benadryl) 50 mg IV PRN x 1 for itching, facial flushing, hives, rash
- MethylPREDNISolone (Solu-Medrol) 125 mg IV PRN x 1 for wheezing, shortness of breath, or symptoms unresponsive to diphenhydrAMINE
- EPINEPHrine 0.3 mg IM PRN x 1 for anaphylaxis
- Famotidine (Pepcid) 20 mg IV PRN x 1 for itching, facial flushing, hives, rash if famotidine not given as premed
- Meperidine (Demerol) 25 mg IV PRN x 1 for severe rigors
- Albuterol (Proventil HFA, Ventolin HFA) 90 mcg/actuation MDI 2 puffs PRN x 1 for dyspnea, wheezing, shortness of breath

Myeloid Growth Factor Therapy: *(Click on drug for drop down list of Biosimilar products)*

☐ None

☐ pegfilgrastim (Neulasta) _____ 6 mg SubQ ONCE. Start 24 hours after chemotherapy on Day _____.

☐ Pegfilgrastim (Neulasta Onpro Delivery Kit) 6 mg SubQ ONCE apply after chemotherapy given.

☐ filgrastim-sndz (Zarxio) _____ 300 mcg SubQ DAILY. Start 24 hours after chemotherapy given on Day _____. Continue DAILY for _____ days (regardless of ANC), then HOLD subsequent dose when ANC is greater than _____.

☐ Other: _____

Supportive Medications [for inpatient use]:

TLS Prophylaxis

☐ Allopurinol (Zyloprim) 300 mg PO BID

Antimicrobial Prophylaxis

☐ Levofloxacin (Levaquin) 500 mg PO daily

☐ Trimethoprim-sulfamethoxazole (Bactrim DS) 160-800 mg tablet PO BID on Mon, Wed, Fri

☐ Acyclovir 400 mg PO BID

☐ Fluconazole 200 mg PO daily

☐ Posaconazole EC (Noxafil) delayed-release tablet 300 mg PO BID x 1 day, followed by 300 mg PO daily

☐ Posaconazole (Noxafil) oral liquid 200 mg PO BID

High-Dose Cytarabine

☐ Polyvinyl alcohol (Artificial Tears) 1.4% ophthalmic solution or Carboxymethylcellulose (Refresh Plus) 0.5% ophthalmic solution 2 drops both eyes QID x 7 days beginning on the same day as High Dose Cytarabine is started

☐ PrednisoLONE acetate (PredForte) 1% ophthalmic suspension 2 drops both eyes QID x 7 days beginning on the same day as High Dose Cytarabine is started

PEMEtrexed

☐ Folic acid 1 mg daily starting 7 days prior to PEMEtrexed

☐ Cyanocobalamin (Vitamin B12) 1,000 mcg IM ONCE within 1 week prior to PEMEtrexed

☐ Other: _____

MD Name (Printed) _____ **MD Signature** _____ **Date / Time** _____

Version Date: April 2023