PROTOCOL CODE: HLHETCSPA

(Week 3 to 8)

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff and platelets, bilirubin, creatinine** day 1 of treatment

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **Other**

**** Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT: Week 3 to 8 ONLY:

☐ **cycloSPORINE 3 mg/kg** x Wt = _____ mg PO BID (round to the nearest 25 mg)
Mitte: _____ capsules

☐ week 3 and 4: **dexamethasone 5 mg/m²** x BSA = _____ mg PO daily (round to the nearest 2 mg)
Mitte: _____ tablets OR
☐ week 5 and 6: **dexamethasone 2.5 mg/m²** x BSA = _____ mg PO daily (round to the nearest 0.5 mg)
Mitte: _____ tablets OR
☐ week 7 and 8: **dexamethasone 1.25 mg/m²** x BSA = _____ mg PO daily (round to the nearest 0.5 mg)
Mitte: _____ tablets

etoposide 150 mg/m² x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 500 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes on **Days 15, 22, 29, 36, 43, 50** (Use non-DEHP tubing with 0.2 micron in-line filter)

EMERGENCY DRUGS FOR MANAGEMENT OF ETOPOSIDE TOXICITY:
hydrocortisone 100 mg IV prn / **diphenhydrAMINE 50 mg** IV prn

See page 2

DOCTOR"S SIGNATURE	**SIGNATURE** **UC:**

PROTOCOL CODE: HLHETCSPA

(Week 3 to 8)

DOCTOR'S ORDERS (Page 2 of 3)

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and weeks _____. Book chemo on Day 1. ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, platelets, creatinine, bilirubin weekly cycloSPORINE trough levels weekly once cycloSPORINE initiated ☐ If clinically indicated: ☐ ALT ☐ LDH ☐ ferritin ☐ CMV DNA levels ☐ EBV DNA levels ☐ lumbar puncture with CSF analysis (cell count and differential, protein and glucose) ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR"S SIGNATURE	**SIGNATURE** **UC:**

PROTOCOL CODE: HLHETCSPA

(Week 3 to 8)

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff and Platelets** prior to day 1, 8 and 15 of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.5 x 10^9/L, Platelets greater than or equal to 40 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

INTRATHECAL (IT) CHEMOTHERAPY:

methotrexate _____mg (standard dose 12 mg) and **hydrocortisone** _____ mg (standard dose 50 mg) qs to 6 mL with preservative-free NS intrathecally on week _____.

RETURN APPOINTMENT ORDERS

☐ Return in 1 week for Doctor and week _____. ☐ Last Cycle. Return in _____ week(s).	
☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

MEDICATION VERIFICATION CHECKS
Full Signatures Required

Date (dd/mm/yy)	
methotrexate _____ mg and hydrocortisone _____ mg IT	(RN)
	(MD)