PROTOCOL CODE: HLHETCSPA

(Week 1 and 2) **(Page 1 of 2)**

DOCTOR'S ORDERS	Ht_____cm Wt_____kg BSA_____m^2

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**, **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 1 and 2 ONLY:

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

dexamethasone 10 mg/m^2 x BSA = _____ mg PO daily (round to the nearest 2 mg)
Mitte: _____ tablets

etoposide 150 mg/m^2 x BSA = _____ mg
   ☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
   IV in 500 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes on **Days 1, 4, 8 and 11.** (Use non-DEHP tubing with 0.2 micron in-line filter)

DOCTOR"S SIGNATURE	SIGNATURE
	UC:

PROTOCOL CODE: HLHETCSPA

(Week 1 and 2) (Page 2 of 2)

DOCTOR'S ORDERS (Page 2 of 2)

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and week 3. Book chemo on Days 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** ☐ **HBV viral load** **Week 3: 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:**