# PROTOCOL CODE: HLHETCSPA

## (Week 3 to 8) 

## 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 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/$m^2$** x BSA = _____ mg PO daily (round to the nearest 2 mg)
Mitte: _____ tablets OR
☐ week 5 and 6: **dexamethasone 2.5 mg/$m^2$** x BSA = _____ mg PO daily (round to the nearest 0.5 mg)
Mitte: _____ tablets OR
☐ week 7 and 8: **dexamethasone 1.25 mg/$m^2$** x BSA = _____ mg PO daily (round to the nearest 0.5 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 15, 22, 29, 36, 43, 50** (Use non-DEHP tubing with 0.2 micron in-line filter)

| **DOCTOR"S SIGNATURE** | **SIGNATURE**<br><br>**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.<br>☐ Last Cycle. Return in _____ week(s). | |
| **CBC & Diff, creatinine, bilirubin** weekly<br>cycloSPORINE trough levels weekly once cycloSPORINE initiated<br>☐ If clinically indicated: ☐ **ALT** ☐ **LDH** ☐ **ferritin** ☐ **CMV DNA levels**<br>☐ **EBV DNA levels**<br>☐ **lumbar puncture with CSF analysis (cell count and differential, protein and glucose)**<br>☐ **HBV viral load**<br>☐ **Other tests:**<br>☐ **Consults:**<br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR"S SIGNATURE** | **SIGNATURE**<br><br>**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 _____.<br>☐ Last Cycle. Return in _____ week(s). | |
| ☐ **Other tests:**<br>☐ **Consults:**<br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |

### MEDICATION VERIFICATION CHECKS
**Full Signatures Required**

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