

PROTOCOL CODE: SAVACM (Inpatient)

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DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
DATE: _____	To be given: _____	Cycle #: _____
Date of Previous Cycle: _____		
☐ alternating with SAIME every 2 or 3 weeks (<i>circle one</i>) ☐ non-alternating regimen every 3 weeks		
☐ Delay treatment _____ week(s) ☐ CBC & Diff day of treatment		
May proceed with doses as written if within 48 hours ANC greater than or equal to $0.75 \times 10^9/L$, platelets greater than or equal to $100 \times 10^9/L$		
Dose modification for: ☐ Hematology ☐ Other Toxicity _____		
Proceed with treatment based on blood work from _____		
INPATIENT TREATMENT		
- Admit to inpatient bed - Refer to inpatient ward policies and procedures for additional orders (e.g., routine vital signs, VTE prophylaxis, etc.)		
ON ADMISSION:		
- CBC & Diff, total bilirubin, creatinine, ALT, alkaline phosphatase, GGT, LDH - Dipstick urine for blood and q8h during treatment (If positive notify MD and send urine sample for urinalysis for verification and accurate determination of hematuria - see supportive care protocol - SCMESNA) - Routine vital signs - Diet and Activity as tolerated		
If clinically indicated: ☐ ECG (before first treatment)		
PREMEDICATIONS:		
dexamethasone ☐ 8 mg or ☐ 12 mg (<i>select one</i>) PO (or ☐ IV) 30 minutes prior to treatment on Day 1 , then dexamethasone 4 mg PO BID for 5 doses		
ondansetron 8 mg PO (or ☐ IV) 30 minutes prior to treatment and q12h for 1 dose		
aprepitant 125 mg PO 30 minutes prior to treatment on Day 1 , then aprepitant 80 mg PO once daily on Days 2 and 3		
NOTE: Reminder to Physician to write outpatient scripts for aprepitant and dexamethasone for day 2 and subsequent doses. Instruct patient to continue antiemetics as per physician's prescription on discharge.		
SUPPORTIVE CARE MEDICATIONS:		
LORazepam 1 mg SL q4h PRN nausea or vomiting prochlorperazine 10 mg PO q6h PRN nausea or vomiting nabilone 1 mg PO q8h PRN nausea or vomiting ☐ Other: _____		
See page 2		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC:

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DATE:

TREATMENT AND HYDRATION:

☐ patient receiving radiation – omit doxorubicin

Hour 0 to 0:30: **vinCRiStine 1.5 mg/m² x BSA = _____ mg (maximum dose = 2 mg)**

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 25 to 50mL NS over 15 minutes

DOXOrubicin 75 mg/m² x BSA = _____ mg

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

IV push

Hour 0:30 to 1:45: **mesna 240 mg/m² x BSA = _____ mg**

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 mL NS over 15 minutes

cyclophosphamide 1200 mg/m² x BSA = _____ mg

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 to 250 mL NS over 60 minutes

Hour 1:45 to 11: D5W-1/2NS IV at 250 mL/h

Hour 5 and 8: **mesna 240 mg/m² x BSA = _____ mg**

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 mL NS over 15 minutes at Hour 5 and 8

OR

mesna 480 mg/m² x BSA = _____ mg

☐ Dose modification: _____ % = _____ mg/m² x BSA = _____ mg

PO in carbonated beverage at Hour 5 and 8 (round dose to nearest 10 mg)

Hour 11 to 24: ☐ Continue D5W-1/2NS IV at 125 mL/h

☐ Discontinue IV hydration at Hour 15 if no hematuria and patient drinking well

Discharge home when IV discontinued or mesna completed and patient not vomiting

RETURN APPOINTMENT ORDERS

- ☐ Admit in **three** weeks for **SAVACM** for _____ days
- ☐ Return in **three** weeks for **SAVACM** for Doctor and Cycle # _____
- ☐ Return in **two** or **three** (circle one) weeks for **SAIME** for Doctor and Cycle # _____
- ☐ Admit in **two** or **three** (circle one) weeks for **SAIME** for _____ days
- ☐ Sarcoma Conference _____ (specify date)
- ☐ Last Cycle. Return to clinic in _____ week(s).

- ☐ **SAVACM:** CBC and Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, GGT, LDH, urine dipstick for blood prior to each cycle
- ☐ **SAIME:** CBC and Diff, creatinine, sodium, potassium, phosphate, albumin, total bilirubin, urine dipstick for blood prior to each cycle

☐ Other tests: ☐ ECG

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: