Diagnosis ____________________________  Allergies: ____________________________

If actual body weight is greater than 30% of the ideal body weight, use adjusted body weight.

- Use Actual Body Weight
- Use Ideal Body weight
- Use Adjusted Body weight

Actual Body Weight (ABW): ___________ kg  Height _____________ in  Actual Body Surface Area (BSA) = ________ m²

Ideal Body Weight (IBW) _______ kg = female: 45.5 kg + (2.3 x height in inches over 5 feet)  Ideal BSA ________ m²

Ideal Body Weight (IBW) _______ kg = male: 50 kg + (2.3 x height in inches over 5 feet)  Ideal BSA ________ m²

Adjusted Body Weight ________kg  Adjusted BSA ________ m²

Adjusted body weight = [(Actual body weight – Ideal body weight) x 0.4] + Ideal body weight

* Verify height and weight upon admission; if greater than 10% difference from actual values, notify the attending physician to re-calculate the dose of chemotherapy.

* For drugs other than chemotherapy, use actual body weight.

Results of 24 hour urine Creatinine Clearance results: __________  Estimated CrCl __________

Date of results _______________

I. PREHYDRATION/HYDRATION  Day (- 8)

- Prehydrate prior to beginning high dose chemotherapy with D5½ NS 1000mL IV over 3 hours ONE TIME on Day (– 8) only (_____/_____/______).
- IF DIABETIC: Prehydrate prior to beginning high dose chemotherapy with ½ NS 1000mL IV over 3 hours ONE TIME on Day (– 8) only (_____/_____/______).

II. MAINTENANCE IV Fluids:

- Day (– 8) (_____/_____/______) through Day (+ 2) (_____/_____/______) D5½ NS 1000 mL + 30 mEq potassium chloride at 100 mL/m² /hour = ________ mL/hour. (Use actual BSA: _______m²).
- IF DIABETIC: Day (– 8) (_____/_____/______) through Day (+ 2) (_____/_____/______) ½ NS 1000 mL + 30 mEq potassium chloride at 100 mL/m² /hour = ________ mL/hour. (Use actual BSA: _______m²)
- Starting Day (+3) (_____/_____/______) D5½ NS 1000 mL + 30 mEq potassium chloride at 100 mL/hr.
- IF DIABETIC: Starting Day (+3) (_____/_____/______) ½ NS 1000 mL + 30 mEq potassium chloride at 100 mL/hr.

III. CHEMOTHERAPY REGIMEN

A. Carmustine (BCNU) Day (– 8) to be given at least 24 hours after 3rd dose of palifermin, if palifermin protocol given. Date/time of third dose of palifermin, if applicable:

Date: _____________   Time:   _______________

- Pre-medication for BCNU: Day (- 8) (_____/_____/______) to be given one hour prior to the administration of carmustine
  - Granisetron 1mg IV ONE TIME
  - Dexamethasone 20 mg IV ONE TIME
  - Acetaminophen 650 mg by mouth ONE TIME
  - Lorazepam 0.25 mg IV ONE TIME

TO  Read back
Order taken by Signature: ____________________________  Date/Time: ____________________________

Physician Signature ____________________________  Date/Time: ____________________________
CONDITIONING REGIMEN ORDERS FOR NON-HODGKIN’S LYMPHOMA – PROTOCOL #2
BEAM (Carmustine/Etoposide/Cytarabine/Melphalan)

☐ Carmustine (BCNU) 300 mg/m² = ______ mg IV over 3 hours ONE TIME on Day (– 8) (_____/_____/____)  
☐ Dose Reduction: % reduction _________ = __________________mg. Dose reduction related to: ________________________

☐ No Dose Reduction.

☐ Morphine 1 mg IV every 10 minutes PRN headache x2 doses if patient develops a headache related to BCNU infusion. If no relief from headache 10 minutes after first dose, may give the second dose.

B. Cytarabine (Ara-C) and Etoposide (VP-16) Days (–7) through Day (–4)

1. ☐ Pre-medication(s) to be given one hour prior to administration of high dose chemotherapy on 
   Day (–7) (_____/_____/____) through Day (–4) (_____/_____/____)
   • Granisetron 1 mg IV every 24 hours x4 days
   • Dexamethasone 20 mg IV every 24 hours x4 days
   • *Ondansetron 8 mg IV daily X 4 doses to be given one hour prior to each EVENING dose of cytarabine on 
     Day (-7) (_____/_____/____), Day (–6) (_____/_____/____), Day (–5) (_____/_____/____), Day (-4) (_____/_____/____)

2. ☐ Cytarabine (Ara-C) 200 mg/m²/dose = _____________ mg IV every 12 hours x 4 days for a total of 8 doses. Infuse 
   each dose over 2 hours.
   Day (-7) (_____/_____/____), Day (-6) (_____/_____/____), Day (-5) (_____/_____/____), Day (-4) (_____/_____/____)
   • Dose Reduction: % reduction _________ = __________________mg. Dose reduction related to: ________________________

☐ No Dose reduction.

3. ☐ Etoposide (200 mg/ m²/day) = ____________mg IV daily X 4 days. Infuse over 2 hours.
   Day (-7) (_____/_____/____), Day (-6) (_____/_____/____), Day (-5) (_____/_____/____), Day (-4) (_____/_____/____)
   • Dose Reduction % reduction _________ = __________________mg. Dose reduction related to: ________________________

☐ No Dose reduction.

C. Melphalan Day (– 3)

☐ Pre-medication to be given one hour prior to melphalan Day (-3) (_____/_____/____).
   • Granisetron 1 mg IV ONE TIME
   • Dexamethasone 20 mg IV ONE TIME
   • If palifermin is not used: 15 minutes prior to administration of melphalan infusion, use 30 mL crushed ice to keep oral 
     mucosa cold, allow to melt in patient’s mouth and repeat until 30 minutes after the infusion.
   • Melphalan 140 mg/m² = ________________mg IV ONE TIME. Infuse over 20 minutes on Day (–3) (___ / ___/ ___)
   • Dose reduction % reduction __________ = ________________mg. Dose reduction related to: ________________________

☐ No Dose reduction.

TO ☐ Read back
Order taken by Signature: ______________________________ Date/Time: ______________________________
Physician Signature ______________________________ Date/Time: ______________________________
IV. Rest: Day (-2) and Day (-1)

☐ Rest Day (-2) (_____/_____/_____) through Day (-1) (_____/_____/_____) 

V. Day of Transplant Day (0)

☐ Pre medication for Stem cell Transplant 30-60 minutes prior to stem cell infusion on Day (0) (_____/_____/_____) 
  ☐ Diphenhydramine 50 mg IV ONE TIME 
  ☐ Hydrocortisone 100 mg IV ONE TIME 
  ☐ Infuse Stem Cells on Day (0) (_____/_____/_____) 

VI. ☐ See separate Palifermin Order sheet for post BMT Palifermin orders. 

VII. Other Orders

____________________________________________________________________________________________ 
____________________________________________________________________________________________ 
____________________________________________________________________________________________ 

☐ TO ☐ Read back 
Order taken by Signature: ___________________________ Date/Time: ___________________________ 
Physician Signature ___________________________ Date/Time: ___________________________