DATE TO BE GIVEN: ___________________________ CYCLE: ___________________________

REGIMEN/PROTOCOL: ETOPOSIDE + METHYLPREDNISOLONE + CISPLATIN + CYTARABINE +/- RITUXIMAB (ESHAP +/- Rituximab)

PRIMARY DIAGNOSIS: □ Non-Hodgkin’s Lymphoma □ Hodgkin’s Lymphoma □ T-cell lymphoma
☐ Other (requires protocol): ___________________________

ALLERGIES/REACTIONS:

Goal of Chemotherapy: □ Curative □ Palliative □ Neoadjuvant □ Adjuvant

MD to indicate which weight to use: □ Actual □ Ideal □ Adjusted

HEIGHT (cm): ACTUAL WEIGHT (kg): IDEAL WEIGHT (kg): ADJUSTED WEIGHT (kg):

and BSA (m²): and BSA (m²): and BSA (m²):

Dosing calculations to be completed by Pharmacist:

<table>
<thead>
<tr>
<th>CHEMOTHERAPY MEDICATION ORDERS</th>
<th>DOSE (mg/m²)</th>
<th>BSA (m²)</th>
<th>DOSE TO BE GIVEN</th>
<th>ROUTE</th>
<th>INFUSE OVER</th>
<th>DATE(S) AND FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order of administration:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 1 =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rituximab</td>
<td>375 mg/m²</td>
<td></td>
<td>Please use Rituximab Physician Order #615</td>
<td>Day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etoposide</td>
<td>40 mg/m²</td>
<td>X</td>
<td>=</td>
<td>IV</td>
<td>1 hour</td>
<td>Days 1-4</td>
</tr>
<tr>
<td>Methylprednisolone (in D5W 50 ml)</td>
<td>= 500 mg</td>
<td>IV</td>
<td>30 minutes</td>
<td>Days 1-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisplatin</td>
<td>25 mg/m²/day</td>
<td>X</td>
<td>=</td>
<td>IV</td>
<td>24 hours</td>
<td>Days 1-4</td>
</tr>
<tr>
<td>Cytarabine</td>
<td>2,000 mg/m²</td>
<td>X</td>
<td>=</td>
<td>IV</td>
<td>2 hours</td>
<td>Day 5 start after etoposide, cisplatin complete</td>
</tr>
</tbody>
</table>

CONTINUOUS IV CHEMOTHERAPY: MAY INCREASE RATE BY ___________________________ TO KEEP WITHIN 24-HOUR DOSE. PATIENT MAY BE OFF CONTINUOUS IV CHEMOTHERAPY NO LONGER THAN 30 MINUTES/24 HOURS

HYDRATION ORDERS

<table>
<thead>
<tr>
<th>HYDRATION SOLUTION</th>
<th>ADDITIVES</th>
<th>RATE</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-chemo hydration optional if hydrated 1.5-2 Liters before or low risk for tumor lysis syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BEFORE CHEMOTHERAPY

DURING CHEMOTHERAPY

AFTER CHEMOTHERAPY

HOLD CHEMOTHERAPY FOR THE FOLLOWING REASONS:

Absolute Neutrophil Count (ANC) Less Than ___________________________ (typically less than 1,000)
Platelets Less Than ___________________________ (typically less than 100,000)
Other: ___________________________

Physician initial: ___________________________

Page 1 of 2

PHYSICIAN ORDERS

CHEMOTHERAPY: ETOPOSIDE + METHYLPREDNISOLONE + CISPLATIN + CYTARABINE +/- RITUXIMAB (ESHAP +/- Rituximab)

Franciscan Health System
St. Joseph Medical Center, Tacoma, WA
St. Francis Hospital, Federal Way, WA
St. Clare Hospital, Lakewood, WA
St. Elizabeth Hospital, Enumclaw, WA
St. Anthony Hospital, Gig Harbor, WA

Revision F
## PHYSICIAN ORDERS
CHEMOTHERAPY: ETOPOSIDE + METHYLPREDNISOLONE + CISPLATIN + CYTARABINE +/- RITUXIMAB (ESHAP +/- RITUXIMAB)

### PHARMACY TO MANAGE ANTIEMETICS

<table>
<thead>
<tr>
<th>ANTIEMETIC ORDERS/DRUG NAME</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>TIMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ondansetron</td>
<td>24 mg</td>
<td>PO</td>
<td>30 minutes pre-chemo (Day 1) THEN daily (Days 2-5)</td>
</tr>
<tr>
<td>Granisetron</td>
<td>2 mg</td>
<td>PO</td>
<td>30 minutes pre-chemo (Day 1) THEN daily (Days 2-5)</td>
</tr>
<tr>
<td>Palonosetron</td>
<td>0.25 mg</td>
<td>IV</td>
<td>30 minutes pre-chemo (Day 1)</td>
</tr>
<tr>
<td>Fosaprepitant</td>
<td>150 mg</td>
<td>IV</td>
<td>30 minutes pre-chemo (Day 1)</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>0.5-1 mg</td>
<td>PO</td>
<td>30 minutes pre-chemo times 1 dose PRN anxiety</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>0.5 mg</td>
<td>PO</td>
<td>Every 6 hours (Days 1-5)</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>1 mg</td>
<td>PO</td>
<td>Every 6 hours (Days 1-5)</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2 mg</td>
<td>PO</td>
<td>Every 6 hours (Days 1-5)</td>
</tr>
</tbody>
</table>

Do not use additional Dexamethasone or Corticosteroids with this regimen unless ordered by Oncologist

### PRN ANTIEMETICS (FOR INPATIENT USE)

**NOTE:** Number the antiemetics below in the order to be used. The nurse will select #1 as the first medication to be given and may alternate #2. If orders chosen are not numbered, the nurse will contact the prescriber for clarification.

<table>
<thead>
<tr>
<th>Antiemetic</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>TIMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>0.5-1 mg</td>
<td>IV</td>
<td>Every 4 hours PRN nausea/vomiting/anxiety</td>
</tr>
<tr>
<td>Promethazine</td>
<td>12.5-25 mg or 6.25-12.5 mg*</td>
<td>IV</td>
<td>Every 4 hours PRN nausea/vomiting</td>
</tr>
</tbody>
</table>

**Outpatient Prescription(s):** (for outpatients or early discharge)

*For patients greater than 65 years of age

**TESTS:**
- ☐ MUGA Scan
- ☐ ECG
- Other: ___________

**LABS – NOW:**
- ☐ CBC
- ☐ BMP
- ☐ CMP
- Other: ___________

**LABS – DAILY:**
- ☐ CBC
- ☐ BMP
- ☐ CMP
- Other: ___________

□ Urine Output: If urine output is less than ___________ give ___________ times ___________ days

☐ Nurse May Initiate CVAD Management Per Nursing Protocol #910.00
☐ Nurse May Utilize Local Anesthetic For CVAD Access Per Nursing Procedure #788.
☐ Nurse May Initiate IV Catheter Care, Outpatient Physician Order #858
☐ Initiate Drug Related Hypersensitivity Orders #774 For Infusion Reactions

**MEDICATIONS:**
- ☐ Dexamethasone 0.1% ophthalmic solution 2 drops in each eye four times daily. Start prior to cytarabine and stop 24 hours after cytarabine complete.
- ☐ Allopurinol 300 mg PO daily
- Other: ___________

**NOTE:** These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated and signed below.

**DATE** | **TIME** | **PHARMACIST’S SIGNATURE**
---|---|---

**DATE** | **TIME** | **PHYSICIAN’S SIGNATURE**
---|---|---

Another brand of drug, identical in form and content, may be dispensed unless checked. ☐