1. **ALLERGIES/REACTIONS:**

2. Height _________ cm  Actual Weight _________ kg

3. Diagnosis: □ CD52 positive B-cell chronic lymphocytic leukemia and fludarabine failure
   □ Other (provide protocol): ____________________________

4. **PRE INFUSION LABS:**  □ CBC  □ CMP  □ HSV GM (IgG/IgM) (unless positive history)

5. **HYDRATION IV:** ____________________________

6. **PRE-MEDICATION:**
   **Opportunistic Infection Prophylaxis:**
   □ Sulfamethoxazole/trimethoprim (Bactrim DS) 800 mg/160 mg PO twice daily three times/week
   □ Acyclovir (Zovirax) 400 mg PO twice daily if HSV positive or if HSV status is unknown until results are available.
   □ Continue prophylaxis for 2 months after completion of alemtuzumab (Campath) therapy or until the CD4+ count is greater than or equal to 200 cells/microliter, whichever occurs later.
   □ Pharmacy to adjust sulfamethoxazole/trimethoprim and/or acyclovir for reduced renal function

   **30 Minutes Pre alemtuzumab (Campath) administer:**
   □ Antiemetic protocol per Pharmacy.
   □ Acetaminophen (Tylenol) 650 mg PO. May repeat every 4 hours PRN chills or temperature greater than 38°C.
   **LIMIT THE TOTAL DOSE OF ALL ACETAMINOPHEN CONTAINING PRODUCTS TO 3,000 MG PER DAY**
   □ Diphenhydramine (Benadryl) 50 mg PO. May repeat every 4 hours PRN rash.
   □ Hydrocortisone (SoluCortef) 200 mg IV

7. **ALEMTUZUMAB (CAMPATH) ADMINISTRATION:**
   □ Alemtuzumab (Campath) _________ mg. Day # _________ of titration.
   **Initial dose 3 mg daily. When tolerated, increase daily dose to 10 mg and continue until tolerated. Then may begin maintenance dose of 30 mg three times/week.**
   **Maximum dose: 30 mg per dose or cumulative doses of 90 mg per week**
   □ Mix in 100 ml 0.9% sodium chloride (Normal Saline)
   □ Cover with brown bag during infusion
   □ Stable for 8 hours protected from light
   □ Infuse alemtuzumab (Campath) over at least 2 hours. **DO NOT** administer as an IV push or bolus.
   □ Do not infuse other medications into the IV line with alemtuzumab (Campath)

8. **TREATMENT:**
   □ Vital Signs: Pre infusion, every 15 minutes during infusion, 30 minutes and 60 minutes post infusion
   □ NOTIFY PHYSICIAN IF:
     • Systolic blood pressure less than __________ mmHg or greater than __________ mmHg
     • Temperature greater than __________ °C
   □ For infusion reactions initiate Drug Related Hypersensitivity Physician Order #774
     • If mild infusion reaction occurs the infusion may be resumed at one-half the previous rate upon improvement of patient symptoms
   □ 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

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

   **DATE**     **TIME**     **PHYSICIAN’S SIGNATURE**

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