

## Physician Orders ADULT

## Order Set: azacitidine

Diagnosis : AML/ MDS

Height: _____ cm	Weight: _____ kg	Cycle: _____ Of : _____
Actual BSA: _____ m <sup>2</sup>	Treatment BSA: _____ m <sup>2</sup>	Day/Wk: _____ Freq: _____
<b>Allergies:</b>		
<input type="checkbox"/> No known allergies		
<input type="checkbox"/> Medication allergy(s): _____		
<input type="checkbox"/> Latex allergy <input type="checkbox"/> Other: _____		
<b>Patient Care</b>		
<input type="checkbox"/> Nursing Communication	T;N, Do not exceed a treatment BSA of _____ m <sup>2</sup>	
<input type="checkbox"/> Nursing Communication	T;N, May hold hydration during chemotherapy infusion	
<b>Continuous Infusions</b>		
<b>Pre Hydration</b>		
<input type="checkbox"/> Normal Saline	1,000 mL, IV, Routine, _____ mL/hr	
<b>Medications</b>		
<b>CHEMOTHERAPY</b>		
<b>Drug (generic) &amp; solution (optional)</b>	<b>Intended Dose</b>	<b>Actual Dose</b>
<b>Route, Infusion, Frequency and total doses</b>		
<b>NOTE: Nurse must call Pharmacy for medication. Short Stability of only 1 hour</b>		
<input checked="" type="checkbox"/> azacitidine	<b>75 mg/m<sup>2</sup></b>	IV Piggyback, Infuse over 30 min, q24h on DAYS 1-7
<b>Acute Emesis Prophylaxis ( may undergo therapeutic interchange)</b>		
<b>NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy</b>		
<input checked="" type="checkbox"/> ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1-7	
<input checked="" type="checkbox"/> dexamethasone	8 mg, Injection, IV Push, Q Day , on DAYS 1 - 7	
<input checked="" type="checkbox"/> prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting	
<input checked="" type="checkbox"/> prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO	
<b>Consults/Notifications</b>		
<input type="checkbox"/> Notify Physician- Once	T;N, Who: _____, For: if BSA exceeds 2 m <sup>2</sup>	

Date

Time

Physician's Signature

MD Number