

IV Q24 BUSULFAN PHARMACOKINETICS REQUISITION

PATIENT INFORMATION

Patient Name: _____ Full Institution Name: _____
 Medical Record #: _____ Date of Birth: _____
 Actual Weight (kg): _____ Genetic Sex (check one): Male / Female
 Dosing Weight (kg): _____ Diagnosis: _____
 Height (cm): _____ ICD-10 Code: _____

DOSE INFORMATION

Date of Dose: _____
 Dose Given (mg): _____
 Busulfan Manufacturer/Lot Number
 (if generic busulfan): _____
 Dose Number: _____
 Total # of Regimen Doses: _____
 Desired Target Range: _____
 Target Units (circle one): (AUC) (AUC) (Css)
 $\mu\text{Mol}\cdot\text{min}$ / $\text{mg}\cdot\text{h/L}$ / ng/mL

CONTACT INFORMATION

Signature of MD or designee: _____
 Attending MD (print name): _____
 Results are usually available between 13:00 and 16:00 Pacific Time the day following sample collection and shipment. Verbal report recipient must be an MD or a PharmD.
 Verbal report recipient: _____
 Verbal report recipient contact number: _____
 Email address(es)/Fax number(s): _____

**ALL INFORMATION MUST BE FILLED OUT PRIOR TO SHIPPING.
 BUSULFAN RESULTS CANNOT BE CALCULATED OR REPORTED WITHOUT COMPLETE INFORMATION.**

IV Q24 Busulfan Dose 1

For a test dose preceeding an IV Q24 regimen please use the IV Q6 requisition

Typical IV Q24 infusion is 180 minutes, including flush

Infusion start time: _____
 Infusion stop time: _____

	ACTUAL Sample Collection Clock Times	Initials
End of Infusion		
End of Infusion + 15 Minutes		
Start of infusion + 4 Hours		
Start of infusion + 5 Hours		
Start of infusion + 6 Hours		
Start of infusion + 8 Hours		

IV Q24 Busulfan Follow-up Doses

Typical IV Q24 infusion is 180 minutes, including flush

Infusion start time: _____
 Infusion stop time: _____

	ACTUAL Sample Collection Clock Times	Initials
Pre Infusion		
End of Infusion		
End of Infusion + 15 Minutes		
Start of infusion + 4 Hours		
Start of infusion + 6 Hours		
Start of infusion + 8 Hours		

Please draw a minimum of 2 mL blood in a green top tube (sodium heparin). Keep refrigerated or on ice at all times. Centrifuge at 4°C. Remove and freeze plasma into a plastic tube labeled with: Patient Name, Medical Record #, Date and Time of Draw. Please tape labels on. Send plasma with 5 kg of dry ice **FIRST OVERNIGHT** to the address below. Accurate blood draw and infusion start/stop times are critical to busulfan PK analysis.

DRUG INTERACTIONS: Please indicate which (if any) of the following drugs the patient has taken within the past 30 days:

Deferasirox, Metronidazole, Itraconazole, Isavuconazole, Voriconazole, Posaconazole, Azithromycin, TKIs, Acetaminophen, Ivosidenib, Enasidenib

Drug(s): _____
 Date of last dose: _____

Please indicate any other drug/treatment the patient has taken or will take as part of their current conditioning regimen:

Cyclophosphamide	Thiotepa	Etoposide
Fludarabine	ATG	TBI
Melphalan	Other: _____	

Please fax or scan and email a completed copy of this requisition form and shipment tracking number to PKLab@seattlecca.org prior to shipping samples, and include a hard copy with the samples. Ship samples frozen with a minimum of 5kg dry ice.

Phone number: (206) 606-7389 Fax number: (206) 606-7397 Pager: (206) 994-5942

Email: PKLab@seattlecca.org

SHIP TO: Pharmacokinetics
 Laboratory
 Seattle Cancer Care Alliance
 188 E. Blaine St. Suite 250
 Seattle, WA 98102