# ORAL 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) µMol*min / (AUC) mg*h/L / (Css) 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.**

## ORAL Busulfan Dose 1

**Time of Dose:** _____

Emesis? Yes No Redose? Yes No Redose Amount: _____ mg

| ACTUAL Sample Collection Clock Times | Initials |
|---|---|
| 30 minutes | |
| 60 minutes | |
| 90 minutes | |
| 2 hours | |
| 3 hours | |
| 4 hours | |
| 5 hours | |
| 6 hours | |

## ORAL Busulfan Follow-up Doses

**Time of Dose:** _____

Emesis? Yes No Redose? Yes No Redose Amount: _____ mg

| ACTUAL Sample Collection Clock Times | Initials |
|---|---|
| Pre-dose | |
| 30 minutes | |
| 60 minutes | |
| 2 hours | |
| 4 hours | |
| 6 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 4ºC. 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