IV Q8 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.

IV Q8 Busulfan Dose 1

For a test dose preceeding an IV Q8 regimen please use a IV Q6 requisition

Typical IV Q8 infusion is 120 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 + 3 Hours		
Start of infusion + 5 Hours		
Start of infusion + 6 Hours		
Start of infusion + 7 Hours		

IV Q8 Busulfan Follow-up Doses

Typical IV Q8 infusion is 120 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 + 3 Hours		
Start of infusion + 6 Hours		
Start of infusion + 7 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