

For anthracycline-induced injection site extravasation

Protocol Types

Infusion Treatment 1, Infusion Treatment 2, Infusion Treatment 3, Infusion Treatment 4

Patient name: _____ DOB: _____

Please include: ☐ Patient face sheet ☐ Insurance authorization (if other than Medicaid or non-Advantage Medicare)

Diagnosis: _____

Review: Every 358 days

Orders

	Interval	Defer Until	Duration
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Nursing Orders

☒ Nursing communication	Every 1 day		3 treatments
Patient should continue to use a cold compress every 6 hours for 72 hours from the time of extravasation. Apply for 15 minutes then remove.			

Ensure cold compress is removed AT LEAST 15 minutes prior to each dexrazoxane administration.

Therapeutic Medications

☒ dexrazoxane IV 1,000 mg/m2	Once		1 treatment
1,000 mg/m2, intravenous, Administer over: 1-2 Hours, Once Initiate as soon as possible and within the first 6 hours after extravasation. Maximum dose is 2,000 mg. Dose is administered in opposite extremity from the extravasation site. Reduce dose by 50% if CrCl < 40 mL/min.			
☒ dexrazoxane IV 1,000 mg/m2	Once	S+1	1 treatment
1,000 mg/m2, intravenous, Administer over: 1-2 Hours, Once, Starting when released Administer infusion at the same hour +/- 3 hours on each day. Maximum dose is 2,000 mg. Dose is administered in opposite extremity from the extravasation site. Reduce dose by 50% if CrCl < 40 mL/min.			
☒ dexrazoxane IV 500 mg/m2	Once	S+2	1 treatment
500 mg/m2, intravenous, Administer over: 1-2 Hours, Once, Starting when released Administer infusion at the same hour +/- 3 hours on each day. Maximum dose is 1,000 mg. Dose is administered in opposite extremity from the extravasation site. Reduce dose by 50% if CrCl < 40 mL/min.			

Appointment Requests

☒ Infusion Appointment Request	Every 1 day	S+1	2 treatments
Status: Future, Expected: S, Expires: S+365, Sched. Duration: 180 minutes, Sched. Tolerance: Schedule appointment at most 0 days before or at most 0 days after Dexrazoxane administration post extravasation. Schedule at the same time each day, +/- 3 hours.			

*Provider signature	Provider printed name	*Date	Time
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*Provider phone#

***Denotes field that must be completed by healthcare worker**