Cyclophosphamide (CYTOXAN) Non-Oncology Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

**** Height, weight, and BSA are required for a complete order if dosing based on BSA****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. This order set should be used for administration of intravenous cyclophosphamide (CYTOXAN) to patients with autoimmune disorders.

LABS:

- ☐ Complete Metabolic Set, Routine, every visit
- ☐ CBC with Auto Differential, Routine, every visit
- ☐ Urine, Microscopic Exam, Routine, every visit
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. TREATMENT PARAMETERS – Hold treatment and notify provider for ANC less than 2000 cells/mm3, WBC less than 4000 cells/mm3, Platelets less than 100,000, Total Bilirubin greater than 3 mg/dL, or estimated Creatinine Clearance less than 10 mL/min.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

HYDRATION:

- ☐ **Pre-hydration**: sodium chloride 0.9% 1,000 mL, intravenous, ONCE, every visit, over 60 minutes, prior to cyclophosphamide
- ☐ **Post-hydration**: sodium chloride 0.9% 1,000 mL, intravenous, ONCE, every visit, over 60 minutes, after cyclophosphamide

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ ondansetron (ZOFRAN) injection, 8 mg, intravenous, ONCE, every visit
- ☐ dexamethasone (DECADRON) injection, 8 mg, intravenous, ONCE, every visit
- ☐ LORazepam (ATIVAN) tablet, 1 mg, oral, AS NEEDED x1 dose for anxiety, nausea/vomiting, every visit

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MEDICATION:

cyclophosphamide (CYTOXAN) in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 60 minutes

- ☐ _____ mg/m2 = _____ mg
- ☐ _____ mg/kg = _____ mg
- ☐ _____ mg

Interval: ***(must check one)***

- ☐ Every 4 weeks for _____ doses
- ☐ Daily x _____ doses
- ☐ Other: _____

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders