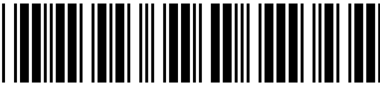
Oregon Health & Science University
Hospital and Clinics Provider's Orders



ADULT AMBULATORY INFUSION ORDER

Cyclophosphamide (CYTOXAN) Non-Oncology

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)(days)(weeks)(months) – *Circle One*
- ☐ CBC with differential, Routine, every ______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ HCG Beta, plasma, Routine, every _______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: ________

HYDRATION: *(Typical volume 500-1,000 mL)*

- ☐ **Prehydration**: sodium chloride 0.9% ___________ mL, intravenous, ONCE, every visit, over 60 minutes, prior to cyclophosphamide
- ☐ **Posthydration**: sodium chloride 0.9% __________ 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) tablet, 16 mg, oral, ONCE, every visit
- ☐ dexamethasone (DECADRON) tablet, 8 mg, oral, ONCE, every visit
- ☐ LORazepam (ATIVAN) tablet, 1 mg, oral, ONCE, every visit

MEDICATION:

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

- ☐ _________ mg/m2 = __________ mg
- ☐ _________ mg/kg = ___________ mg
- ☐ _________ mg

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

- ☐ Once
- ☐ Daily x ___ doses
- ☐ Every ____ weeks for ___ doses
- ☐ Other: ______________________________

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NURSING ORDERS:

1. TREATMENT PARAMETERS – Hold treatment and notify provider if WBC less than 4000 cells/mm3, ANC less than 2000 cells/ mm3, or platelets less than 100,000, serum creatinine greater than 1.5 mg/dL, total bilirubin greater than 3, or temperature greater than 38 °C.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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:**_____________

OLC Central Intake Nurse:

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