ADULT AMBULATORY INFUSION ORDER

Cyclophosphamide (CYTOXAN)
Non-Oncology Infusion

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
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 (Peptic) 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: __________________________
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

- **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

- **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

- **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](http://www.ohsuknight.com/infusionorders)