OHSU	ADULT AMBULATOR Cyclophosphar Non-Oncol	Science University cs Provider's Orders	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE Patient Identification			
Page 1 of 3 ALL ORDERS MUST BE MARKED			DIN INK WITH A CHECKMARK (✓) TO BE ACTIVE.			
	kg	Height:	cm			
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:

- 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:

- □ **Prehydration**: sodium chloride 0.9% 1,000 mL, intravenous, ONCE, every visit, over 60 minutes, prior to cyclophosphamide
- □ **Posthydration**: 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) tablet, 8 mg, oral, 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

OHSU	Oregon Health & Science University Hospital and Clinics Provider's Orders					
		ACCOUNT NO.				
	ADULT AMBULATORY INFUSION ORDER	MED. REC. NO.				
	Cyclophosphamide (CYTOXAN)	NAME				
	Non-Oncology Infusion	BIRTHDATE				
	Page 2 of 3	Patient Identification				
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.						

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 (Policy HC-PAT-133-GUD). 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 x1 dose for hypersensitivity reaction
- 3. EPINEPHrine HCI (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
- 4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
- 5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction

By signing below, I represent the following:

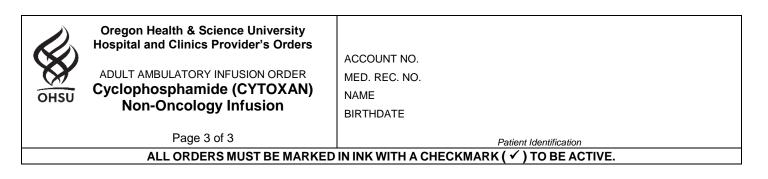
I am responsible for the care of the patient (who is identified at the top of this form); I hold an active, unrestricted license to practice medicine in:
Oregon (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

 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:



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



Infusion Services 364 SE 8th Ave, Medical Plaza Suite 108B Hillsboro, OR 97123 Phone number: (503) 681-4124 Fax number: (503) 681-4120



A Planetree Patient-Centered Hospital

Celilo Cancer Center 1800 E 19th St The Dalles, OR 97058 Phone number: (541) 296-7585 Fax number: (541) 296-7610