INTRAVENOUS CYCLOPHOSPHAMIDE (Cytoxan®)
FOR ANCA VASCULITIS
PHYSICIAN ORDER SHEET
Adapted by Dr. S. Haig

NON-MEDICATION ORDERS
EACH NEW ORDER MUST BE SIGNED AND DATED

On patient arrival please send the following laboratory studies STAT:
☐ CBC, platelets
☐ BUN/ Creatinine
☐ Electrolytes
☐ Urine R&M

Please inform the treating physician of the results of the CBC prior to initiating the Cyclophosphamide infusion.

☐ Weight (Kg) __________

PRIOR TO DISCHARGE

Bloodwork
☐ CBC, Platelets, Creatinine, & Urinalysis to be done 10-14 days post treatment and results faxed to: ______________

Teaching
☐ Call Rheumatologist if hematuria occurs
☐ Drink at least 8 cups of water in the 24 hour period following the infusion
☐ Void frequently for the first 24 hours post treatment

*Dosing Protocol:
• Standard Dosing: 15mg/kg
• Age > 60 decrease by 2.5 mg/kg
• Cr > 300 decrease by 5 mg/kg
• Leukopenic nadir (WBC 2-3) decrease by 20%
• Leukopenic nadir (WBC 1-2) decrease by 40%

DRUG ALLERGIES

List Drug                                      Describe Reactions/Allergies
________________________________________________________________________
________________________________________________________________________
No known drug reaction/allergies

MEDICATION ORDERS

CYCLOPHOSPHAMIDE TREATMENT TIMELINE
• Week 0, 2, 4 and q 3 weeks thereafter.
• Continue cyclophosphamide until remission achieved. Consider consolidation phase for 3 months beyond remission. Continue for maximum 6 months. Re-assess thereafter.

CYCLOPHOSPHAMIDE INFUSION
1. Start IV of ☐ N/S ☐ D5N/S ☐ D5/45 and run ________ mL/hr for a total of __________ hour(s)

2. Before Cyclophosphamide Infusion please give:
☐ _______ mg Ondansetron PO 1 hour prior (4-8 mg)
☐ _______ mg Ondansetron IV over 15 minutes (4-8 mg)

3. IV Cyclophosphamide _________ mg in ________ mL (250) Normal Saline over 1 hour. (Max dose 1.2 g.)

4. Other: ________________________________________________

POST-CYCLOPHOSPHAMIDE INFUSION

☐ ________ mg Ondanestron IV over 15 minutes (4-8 mg) OR
☐ ________ mg Ondansetron PO (4-8 mg)
☐ Other: ________________________________________________

PRIOR TO DISCHARGE

☐ Ondansetron _________ mg PO q8h x 2 doses (4-8 mg)
☐ Other: ________________________________________________

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME

AUTHORIZED PHYSICIAN'S SIGNATURE