INTRAVENOUS CYCLOPHOSPHAMIDE (Cytoxan®)
FOR ANCA VASCULITIS
PHYSICIAN ORDER SHEET
Based on deGroot et al. Annals of Int Med. 2009;150:670-680.
Adapted by Dr. S. Haig

Rheuminfo

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	YR.	MO.	DAY	TIME
PHYSICIAN'S PRINTED NAME	AUTHORIZED PHYSICIAN'S SIGNATURE			