INTRAVENOUS CYCLOPHOSPHAMIDE (Cytoxan®)
PHYSICIAN ORDER SHEET

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

PRE-CYCLOPHOSPHAMIDE INFUSION

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.

PRIOR TO DISCHARGE

Bloodwork

- ❑ CBC, Platelets, Creatinine, & Urinalysis to be done 14 days post treatment and results faxed to: _______________

Teaching

- ❑ Call Rheumatologist if hematuria occurs
- ❑ Drink 250 mL (1 cup) of water every hour for 24 hours
- ❑ Void frequently for the first 24 hours post treatment

DRUG ALLERGIES

List Drug Describe Reactions/Allergies

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No known drug reaction/allergies

MEDICATION ORDERS

CYCLOPHOSPHAMIDE STANDING ORDER INFUSION

- ❑ q______________*(monthly)* infusions x ___________ months *THEN*
- ❑ q______________*(3monthly)* infusions X __________ months

CYCLOPHOSPHAMIDE INFUSION

1. Start IV of ❑**N/S** ❑ **D5N/S** ❑ **D5/45** and run __________ **mL/hr** for _______ **hour(s)**
2. Give ____________ **mg of Methylprednisolone (Solumedrol®)** in 100 mL Normal Saline over 30 minutes.
3. Before Cyclophosphamide Infusion please give:
   - ❑ _______ **mg Dexamethasone IV** 1 hour prior *(10 mg)*
   - ❑ _______ **mg Metoclopramide IV** 1 hour prior *(10 mg)*
   - ❑ _______ **mg Ondansetron PO** 1 hour prior *(4-8 mg)*
   - ❑ _______ **mg Ondansetron IV** over 15 minutes *(4- 8 mg)*
   - ❑ _______ **mg MESNA** just prior to the infusion *(180 mg)*
4. **IV Cyclophosphamide** __________ **mg in** _______ **mL** *(250)* Normal Saline over 1 hour *(0.5-1 g/m2 = 500 – 1000 mg)*

POST-CYCLOPHOSPHAMIDE INFUSION

1. After the Cyclophosphamide Infusion please give:
   - ❑ _______ **mg Dexamethasone IV** 4 hours after infusion *(10 mg)*
   - ❑ _______ **mg Ondanestron IV** over 15 minutes *(4-8 mg)* OR
   - ❑ _______ **mg Ondansetron PO** *(4-8 mg)*
   - ❑ _______ **mg MESNA** _________ hours after infusion *(180 mg)*
2. Continue IV of ❑**N/S** ❑ **D5N/S** ❑ **D545** at ___________ mL/hr for _______ hours then D/C IV.

PRIOR TO DISCHARGE

- ❑ **Ondansetron** ___________ **mg PO** q8h x 2 doses *(4-8 mg)*
- ❑ **Metoclopromide** _________ **mg PO** qid x 48 hours *(10 mg)*
- ❑ **Dexamethasone** _________ **mg PO** q8h x 48 hours *(4-6 mg)*
- ❑ Other:____

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