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: __________________________
No known drug reaction/allergies

MEDICATION ORDERS

CYCLOPHOSPHAMIDE STANDING ORDER INFUSION
- q___________ (monthly) infusions x _________ months THEN
- q___________ (3 monthly) 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 Methyl prednisolone (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 (4-8 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
- Ondanestron _________ mg PO q8h x 2 doses (4-8 mg)
- Metoclopramide _________ mg PO qid x 48 hours (10 mg)
- Dexamethasone _________ mg PO q8h x 48 hours (4-6 mg)
- Other: __________________________

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME

AUTHORIZED PHYSICIAN'S SIGNATURE

YR. MO. DAY