LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order CYCLOPHOSPHAMIDE NON-ONCOLOGY (CYTOXAN)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
****This plan will expire after 365 days, unless otherwise specified below****
****Height, weight, and BSA are required for a complete order if dosing based on BSA****

Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note**
2. This order set should be used for administration of intravenous cyclophosphamide (CYTOXAN) to patients with autoimmune disorders

LABS TO BE DRAWN within 4 days of Treatment (orders must be placed in TVC EPIC by ordering provider if TVC provider):

- ☐ Complete Metabolic Panel, Routine, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ CBC with differential, Routine, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ Other: _____

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- ☐ ondansetron (Zofran) 16 mg P, ONCE, every visit
- ☐ dexamethasone (Decadron) 8 mg PO, ONCE, every visit
- ☐ lorazepam (Ativan) 1 mg PO, ONCE, as needed for nausea or anxiety every visit
- ☐ Other: _____ ONCE, every visit

HYDRATION: (Typical volume 500 – 1000 mL)

- ☐ **Pre-hydration:** sodium chloride 0.9% _____ mL IV over _____ minutes, prior to cyclophosphamide
- ☐ **Post-hydration:** sodium chloride 0.9% _____ mL IV over _____ minutes, after cyclophosphamide

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MEDICATIONS: (must check at least one):

- ☐ cyclophosphamide (Cytoxan) _____ **mg/m2** = _____ mg rounded to _____mg in NaCl 0.9% 250 mL IV over 60 minutes, every visit

- ☐ cyclophosphamide (Cytoxan) _____ **mg/kg** = _____ mg rounded to _____mg in NaCl 0.9% 250 mL IV, ONCE over 60 minutes, every visit (Max dose = _____ mg)

- ☐ cyclophosphamide (Cytoxan) _____ **mg** in NaCl 0.9% 250 mL IV, over 60 minutes, every visit

INTERVAL:

- ☐ Once
- ☐ Daily x _____ doses
- ☐ Every ____ weeks x _____doses
- ☐ Other _____

AS NEEDED MEDICATIONS:

- acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise
- diphenhydramine 25-50 mg oral, EVERY 4 HOURS AS NEEDED for itching

NURSING ORDERS (TREATMENT PARAMETERS):

1. Treatment parameters, every visit: Hold treatment and notify provider if WBC less than 4000 cells/mm3, ANC less than 2000 cells/mm3, or platelets less than 100,000, serum creatinine greater than 1.5 mg/dL, total bilirubin greater than 3, or temperature greater than 38 degrees Celsius, or pregnancy
2. Vital signs, every visit: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion
3. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters.
4. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. diphenhydramine 25-50 mg IV AS NEEDED x1 for hypersensitivity reaction (Max dose: 50 mg)
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction

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

☐ **Legacy Day Treatment Unit**
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ **Legacy Emanuel Day Treatment Unit**
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ Fax: _____

Organization/Department: _____