Cyclophosphamide (CYTOXAN)  
Infusion Therapy Plan Orders

Instructions to Provider
Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers page 2). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

<table>
<thead>
<tr>
<th>Order Date: _____________</th>
<th>Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: _______ kg</td>
<td>ICD-10 code (REQUIRED): ____________________</td>
</tr>
<tr>
<td>Height: _______</td>
<td>ICD-10 description______________________________________________</td>
</tr>
<tr>
<td>BSA: _______ m²</td>
<td>______________________________________________</td>
</tr>
</tbody>
</table>

General Plan Communication
• Special instructions/notes: ________________________________

Infusion Therapy
☑ cyclophosphamide (CYTOXAN) in 0.9% sodium chloride 250 mL IV infusion

<table>
<thead>
<tr>
<th>Dose: _______ mg (will be rounded the nearest 100 mg)</th>
<th>(Or) Dose: _______ mg (will be rounded the nearest 100 mg) = _______ mg/kg x weight (kg)</th>
<th>(Or) Dose: _______ mg (will be rounded the nearest 100 mg) = _______ mg/m² x BSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route: Intravenous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency: ☐ every _____ weeks x 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Infusion Duration: over 60 minutes
May infuse subsequent cyclophosphamide infusions over 30 minutes if no adverse reaction to prior doses.

Note any changes to above regimen:

☐ 0.9% sodium chloride IV infusion (Pre-hydration)

<table>
<thead>
<tr>
<th>Route: Intravenous</th>
<th>Frequency: Prior to each cyclophosphamide infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose: ☐ 250 mL ☐ 500 mL ☐ 1,000 mL ☐</td>
<td>Infusion Duration: ☐ over 60 minutes ☐ over 120 minutes ☐</td>
</tr>
</tbody>
</table>

☐ 0.9% sodium chloride IV infusion (Post-hydration)

<table>
<thead>
<tr>
<th>Route: Intravenous</th>
<th>Frequency: After each cyclophosphamide infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose: ☐ 250 mL ☐ 500 mL ☐ 1,000 mL ☐</td>
<td>Infusion Duration: ☐ over 60 minutes ☐ over 120 minutes ☐</td>
</tr>
</tbody>
</table>

☐ Mesna in 0.9% sodium chloride 50 mL IV infusion

<table>
<thead>
<tr>
<th>Route: Intravenous</th>
<th>Frequency: over 15 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose: _______ mg (will be rounded the nearest 100 mg)</td>
<td>Infusion Duration: over 15 minutes</td>
</tr>
</tbody>
</table>

Pre-Meds
☑ ondansetron (ZOFRAN) tablet

<table>
<thead>
<tr>
<th>Dose: 16 mg</th>
<th>Route: Oral</th>
<th>Frequency: Once, 30 minutes prior to cyclophosphamide infusion.</th>
</tr>
</thead>
</table>

☐ dexamethasone (DECADRON) tablet

<table>
<thead>
<tr>
<th>Dose: 8 mg</th>
<th>Route: Oral</th>
<th>Frequency: Once, 30 minutes prior to cyclophosphamide infusion.</th>
</tr>
</thead>
</table>

☐ Other:

<table>
<thead>
<tr>
<th>Dose: _______</th>
<th>Route: Oral</th>
<th>Frequency: Once, 30 minutes prior to cyclophosphamide infusion.</th>
</tr>
</thead>
</table>

Provider Signature: ____________________________________________   Date: _______________
Printed Name: ______________________________________  Phone: ___________ Fax: ___________
Cyclophosphamide (CYTOXAN) Infusion Therapy Plan Orders

Page 2 of 2

Provider Signature: ____________________________________________   Date: _______________
Printed Name: ______________________________________  Phone: ___________ Fax: ___________
Revision Date: 7/5/2017 Kaiser Permanente   <Reference#115115>

IV Line Care

✓ 0.9% sodium chloride infusion 250 mL
  Rate: 30 mL/hr  Route: Intravenous  Frequency: Run continuously to keep vein open
  Start peripheral IV if no central line
✓ heparin flush 100 unit/mL
  Dose: 500 units  Route: Intracatheter  Frequency: PRN for IV line care per Nursing Policy

Infusion Reaction Meds

✓ albuterol (PROVENTIL) nebulizer solution 0.083%
  Dose: 2.5 mg  Route: Nebulization  Frequency: PRN for shortness of breath/wheezing
✓ diphenhydrAMINE (BENADRYL) injectable
  Dose: 25 mg  Route: Intravenous  Frequency: Once PRN, May repeat x1 for urticaria, pruritis, shortness of breath. May repeat in 15 minutes if symptoms not resolved.
✓ EPINEPHrine 1 mg/mL (1:1000) injectable
  Dose: 0.3 mg  Route: Intramuscular  Frequency: Once PRN for anaphylaxis. Notify physician if administered.
✓ hydrocortisone sodium succinate (SOLU-CORTEF) injectable
  Dose: 100 mg  Route: Intravenous  Frequency: Once PRN for hypersensitivity

Lab Review for Nursing
- Do not administer and call provider if labs are within these parameters:
  - WBC less than 4.0; platelets less than 100,000 K/uL

Nursing Orders
- Weight should be recorded at least every 6 months or more frequently as appropriate. Notify physician if weight has changed 10% or greater from baseline.
- Instruct patient on importance of maintaining oral intake of at least 2 liters per day for 72 hours.
- Instruct patient to contact health care team if not voiding or taking adequate fluids frequently for 72 hours.
- Discontinue IV line when therapy complete and patient stabilized.

References
- Cyclophosphamide Prescribing Information.

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3512  Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104  Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1659  Phone: 425-261-1681

Olympia Medical Center
700 Lily Road N.E., Olympia, WA 98506
Fax: 360-923-7106  Phone: 360-923-7164

Riverfront Medical Center – Spokane
732 North River Drive, Spokane, WA 99201
Fax: 509-524-7168  Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7493  Phone: 360-307-7444

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-6262  Phone: 253-596-3666

Provider Signature: ____________________________   Date: _____________
Printed Name: ____________________________  Phone: ___________ Fax: ___________
Revision Date: 7/5/2017 Kaiser Permanente   <Reference#115115>