KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

# 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:***

**Order Date**: _____

**Weight:** _____kg
**Height**: _____ **BSA:** _____$m^2$

**Diagnosis:**
ICD-10 code *(REQUIRED):* _____

ICD-10 description_____
_____

### General Plan Communication

- Special instructions/notes: _____

### Infusion Therapy

☑ **cyclophosphamide (CYTOXAN) in 0.9% sodium chloride 250 mL IV infusion**
***Dose:*** _____ **mg (will be rounded the nearest 100 mg)**
**(Or) Dose:** _____ **mg (will be rounded the nearest 100 mg) = _____ mg/kg x weight (kg)**
**(Or) Dose:** _____ **mg (will be rounded the nearest 100 mg) = _____ mg/$m^2$ x BSA**

*Route:* Intravenous
*Frequency:* ☐ **every _____ weeks x 6 months**
☐ _____
*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)**
*Route:* Intravenous
*Frequency:* **Prior to each cyclophosphamide infusion**
***Dose:*** ☐ **250 mL** ☐ **500 mL** ☐ **1,000 mL** ☐ _____
*Infusion Duration:* ☐ **over 60 minutes** ☐ **over 120 minutes** ☐ _____

☐ **0.9% sodium chloride IV infusion (Post-hydration)**
*Route:* Intravenous
*Frequency:* **After each cyclophosphamide infusion**
***Dose:*** ☐ **250 mL** ☐ **500 mL** ☐ **1,000 mL** ☐ _____
*Infusion Duration:* ☐ **over 60 minutes** ☐ **over 120 minutes** ☐ _____

☐ **Mesna in 0.9% sodium chloride 50 mL IV infusion**
*Route:* Intravenous
*Frequency:* _____
***Dose:*** _____ **mg (will be rounded the nearest 100 mg)**
*Infusion Duration:* over 15 minutes

### Pre-Meds

☑ ondansetron (ZOFRAN) tablet
*Dose:* 16 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to cyclophosphamide infusion.

☐ dexamethasone (DECADRON) tablet
*Dose:* 8 mg *Route:* Oral
*Frequency:* Once, 30 minutes prior to cyclophosphamide infusion.

☐ Other: _____
*Dose:* _____ *Route:* Oral *Frequency:* Once, 30 minutes prior to cyclophosphamide infusion.

**Provider Signature:** _____ **Date:** _____

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

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### 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, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
*Dose:* 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. 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: 425-261-1578 Phone: 425-261-1566**

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

**Riverfront Medical Center – Spokane**
*W 322 North River Drive, Spokane, WA 99201*
**Fax: 509-324-7168 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:** _____