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  
BSA: ___________m²

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)  
☐ CBC with differential, Routine, every _____(visit)(days)(weeks)(months)  
☐ Other: ____________________________________________

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

☐ ondansetron (Zofran) 8 mg PO, 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

Last updated 2/2024
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 x1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction
Patient Name: 
Date of Birth: 
Med. Rec. No (TVC MRN Only):

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

☐ Legacy Day Treatment Unit – The Vancouver Clinic Building  
A department of Salmon Creek Medical Center  
700 NE 87th Avenue, Suite 360  
Vancouver, WA 98664  
Phone number: 360-896-7070  
Fax number: 360-487-5773

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

☐ Legacy Salmon Creek Day Treatment Unit  
Legacy Salmon Creek Medical Center  
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 Woodburn STEPS Clinic  
A department of Silverton Medical Center  
Legacy Woodburn Health Center  
1475 Mt Hood Ave  
Woodburn, OR 97071  
Phone number: 503-982-1280  
Fax number: 503-225-8723

Provider signature: ___________________________ Date/Time: ___________________________

Printed Name: ___________________________ Phone: ___________ Fax: ___________

Organization/Department: ___________________________

Last updated 2/2024