

NAME:
 BIRTHDATE:
 INSURANCE:
 PROVIDER NAME:
 CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Height & weight are required for a complete order. Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.** GUIDELINES FOR ORDERING:**

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.

REQUIRED Pre-screening labs: We will place these as standing orders and coordinate the labs to be drawn the day before or day of each infusion.

- ✓ CBC with differential
- ✓ Comprehensive Metabolic Panel
- ✓ HCG, serum, quant for female patients
- ✓ Hep B Core Antibody INCLUDE IN FAX IF ALREADY RESULTED, MUST BE WITHIN THE LAST YEAR.
- ✓ Hep B Surface Antigen INCLUDE IN FAX IF ALREADY RESULTED, MUST BE WITHIN THE LAST YEAR.
- ✓ Hep B Surface Antibody INCLUDE IN FAX IF ALREADY RESULTED, MUST BE WITHIN THE LAST YEAR.

TREATMENT PARAMETERS: If the following parameters are not met, pharmacy will call provider to discuss.

- ✓ ANC greater than or equal to 1,500/uL
- ✓ Platelets greater than or equal to 100,000/uL
- ✓ Hgb greater than or equal to 8 g/dL
- ✓ Serum creatinine less than 1.5 mg/dL
- ✓ T bili less than or equal to 1.5 times the upper limit of normal
- ✓ AST and ALT less than 3 times the upper limit of normal.
- ✓ Hepatitis B Core Antibody non-reactive
- ✓ Hep B Surface Antigen non-reactive
- ✓ Hep B Surface Antibody positive, indicating immunity

FOR FEMALE PATIENTS: Negative pregnancy test is required prior to receiving infusion.

- Check here ONLY If your patient **does not** need negative pregnancy test confirmed. If selected, please list reason for this decision: _____.

RECOMMENDED PRE-MEDICATIONS: Choose only ONE of each med. To administer 30 minutes prior to infusion.

- Dexamethadone (decadron) 12 mg tablet, PO.
- Ondansetron (zofran) 24 mg tablet, PO.
- Dexamethasone (decadron) 12 mg in NS 0.9% 50 ml iv, infuse over 15 minutes.
- Ondansetron (zofran) 16 mg in NS 0.9% 50 ml iv, infuse over 15 minutes.
- Other: Medication: _____, Dose: _____, Route: _____.

HYDRATION: (If the hydration bolus is contraindicated for your patient, please cross out pre & post order below)

- ✓ Pre & Post: Sodium chloride 0.9% (NS) bolus 500 ml infuse over 1 hour prior to cyclophosphamide infusion & repeat hydration bolus after.

MEDICATION:

- ✓ **Cyclophosphamide** in sodium chloride 0.9% 250 ml or 500 ml, infuse over 60 minutes. Dilution dependent on dose selected below and will follow pharmacy recommendation.

DOSE: (must select one)

- 500 mg
- 1000 mg
- 1500 mg
- 750 mg/m² (accurate weight & height must be listed at top of order form)
- Other: _____.

NAME:
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FREQUENCY: (must select one)

- This is a ONE TIME dose only.
- Every 2 weeks x ____ doses total.
- Every 2 weeks x ____ doses, then every ____ weeks x ____ doses.
- Other: _____

Standard included Nursing Orders:

- ✓ Vital signs per policy or institution protocol.
- ✓ Insert peripheral IV if no iv access.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.
- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately. See hypersensitivity reaction order set below.

HYPERSENSITIVITY INFUSION REACTION ORDERS

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.


1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction. Starting when released.
- DiphenhydrAMINE (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis, starting when released. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction p. Starting when released, For 1 dose. Shake well. Use with spacer.
- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *SEVERE* Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.
- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.


PROVIDENCE
 Health & Services
 ADULT AMBULATORY INFUSION ORDER
Cyclophosphamide (CYTOXAN) Non-Oncology
Infusion
01/2024

NAME:
 BIRTHDATE:
 INSURANCE:
 PROVIDER NAME:
 CLINIC NAME and Phone number:

Patient identification

- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity.

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

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

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |