 <p>ADULT AMBULATORY INFUSION SERVICES 9/2025 Mitomycin (Mutamycin) Bladder Instillation for Oncology patient</p>	<p>NAME: BIRTHDATE: INSURANCE: PROVIDER NAME: CLINIC NAME and Phone number:</p>
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Weight: _____ kg Height: _____ cm Allergies: _____

- 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.**
- 3) Send a copy of related lab results if not available for review in Epic.

Treatment LABS: All lab tests must be completed every visit or within X hours prior to receiving treatment. Please fax lab results, if none received the labs below will be drawn and/or coordinated by OPI.

- ✓ Culture, Urine, STAT, PRN (if indicated, see nursing orders below)
- ✓ Female patients only: HCG, serum, quant, STAT prior to first dose (if indicated, see below)

ICD 10 Diagnosis Code: _____. Dx Description: _____.

PRE-MEDICATIONS:

- ✓ Lidocaine (Xylocaine) 2% jelly (uro-jet) 10 mL, Urethral, Once PRN, to reduce pain with catheter placement, unless allergic to lidocaine.

MEDICATION & DOSE:

- ✓ **Mitomycin (Mutamycin) 40mg in sterile water bladder installation (2mg/ml).** Prior to installation (after catheter placement), any residual urine in the bladder should be drained out prior to instilling the medication. Instill mitomycin-c via Foley catheter, clamp catheter for 45 min retention time (or per local policy), then unclamp catheter and drain bladder for 15 min before removing catheter and disposing of catheter bag and contents per mitomycin-c disposal protocol. For bladder instillation only. Do not refrigerate.

FREQUENCY: *(Select & complete only one option.)*

FOR ONE-TIME TREATMENT:


- ☐ Give treatment ONCE on: (insert specific date or date range) _____.
 If patient has had a previous dose, what date was treatment administered? _____.

FOR WEEKLY TREATMENTS:

- ☐ Patient has NOT had any previous doses.
 Give treatment once WEEKLY for 6 weeks (Cycle 1).
***If treatment plan changes, notify us ASAP for next steps on how to change or discontinue orders.**
- ☐ Patient has initiated treatment and had previous dose(s) elsewhere.
 Date of last dose: _____. The last dose was treatment week: _____.
 Continue with treatment once WEEKLY for _____ more weeks.
***If treatment plan changes, notify us ASAP for next steps on how to change or discontinue orders.**

FOR MONTHLY TREATMENTS: This option is only available if patient has completed Cycle 1 weekly treatments

- ☐ Administer treatment once MONTHLY for _____ cycles.
 If patient has had previous dose(s) elsewhere.
 Date of last dose: _____ which was Cycle _____.
*** If treatment plan changes, notify us ASAP for next steps on how to change or discontinue orders.**

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IV ACCESS: Select only one.

- ☐ Patient DOES have a central line or port.
 - ✓ Dressing change & central line/port flush, PRN.
 - ✓ Alteplase (cathflo activase) injection 2 mg, for clotted or sluggish line, PRN.
- ☐ Patient does NOT have central line or port, will need peripheral iv placed in case of infusion reaction.

LINE OF TREATMENT:

- ☐ First
- ☐ Second
- ☐ Third
- ☐ Adjuvant
- ☐ Neoadjuvant

TREATMENT GOAL:

- ☐ Curative
- ☐ Palliative
- ☐ Control
- ☐ Maintenance

CONSENT & PARQ:

- ☐ By checking this box, I acknowledge that I have reviewed the risks and benefits of Mitomycin with the patient. PAR-Q and informed consent are complete.

FOR FEMALE PATIENTS ages 18-55 years old: Select ONE of the options below; if female patient is outside of this age range skip this section.

- ☐ Patient requires negative pregnancy test prior to initiating therapy. (Our team will coordinate patient completing this prior to first infusion, see above.)
OR
- ☐ Patient does not need negative pregnancy test confirmed. Circle one (or BOLD one if filling out electronically) of the following reasons for this decision: postmenopausal; hysterectomy or bilateral salpingo-oophorectomy; ovarian failure; tubal ligation or another surgical sterilization procedure.

Nursing Orders:

- ✓ Verify that patient has prescription for sodium bicarbonate and oxybutynin and has taken evening and morning dose as prescribed.
- ✓ Check vital signs prior to starting chemotherapy.
- ✓ Insert indwelling urinary catheter: On admit, in prep for chemotherapy bladder installation & then remove it prior to discharge.
- ✓ If a patient feels unwell with dysuria or other irritative bladder symptoms, has had a recent fever, or has had gross hematuria that day, instillation should be deferred.
- ✓ If patient presents with dysuria or other irritative bladder symptoms, order & send urine for culture, and discuss findings with the prescribing clinician.
- ✓ Confirm negative pregnancy test prior to first dose if this applies to patient (see above).
- ✓ For female patients ages 18-55, for subsequent cycles/doses confirm patient is using effective birth control if sexually active; if any concern about the possibility of pregnancy, please order 'HCG, serum, quant. ONE TIME' lab order prior to additional treatment(s).

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Standard included Nursing Orders:

- ✓ Insert peripheral IV if no iv access.
- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ If hypersensitivity or infusion reactions develop, see section below for instructions.
- ✓ For mild reaction monitor vital signs every 5 minutes until back to baseline, then every 15 minutes until resolution of symptoms.
- ✓ For moderate or severe reaction monitor vital signs every 2 minutes until patient is stable, then every 5 minutes for 30 minutes, then every 15 minutes until back to baseline.

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 of chemotherapy/biotherapy, 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 of chemotherapy/biotherapy, 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.

RESUME INFUSION IF:

MILD or MODERATE REACTION:


1. Resume infusion when symptoms resolve, at rate instructed by MD.
2. Continue to monitor for signs and symptoms of reaction and monitor vital signs as recommended per the specific age.
3. Notify MD for signs or recurrent infusion reaction for further instructions.

SEVERE REACTION:

1. Do NOT resume infusion.
2. Continue to monitor closely for signs and symptoms of reaction and monitor vital signs as recommended per the specific agent.
3. Notify MD for signs of continued infusion reactions for further instructions.

MEDICATIONS:

- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate or severe reaction. 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, may repeat x1. For bronchospasm or hypoxemia.

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- 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. For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate or severe reaction. 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 (no mobility devices used)
 - ☐ Uses assistive device (walker, cane)
 - ☐ Uses a wheelchair, but can transfer with minimal or no assistance
 - ☐ Moderate to maximum assistance with mobility, explain: _____
- *Clinic location will reach out if unable to accommodate mobility assistance needs.

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:

This medication may not be available at all locations, intake team will process referral for a location able to provide this treatment.

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |