BARNES-JEWISH Hospital HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

CYCLOPHOSPHAMIDE (CYTOXAN) ORDERS

ADDRESSOGRAPH

UNLESS THE WORD SPECIFIC IS WRITTEN AFTER A DRUG ORDER BY TRADE NAME, A GENERIC EQUIVALENT DRUG APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE MAY BE DISPENSED IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS.

Please check (✔) the appropriate box (☐) and fill in the blank(s) as needed.

DATE	TIME	ORDERS
		IV Fluids: Fluid load should be modified to _____ ml/hour in debilitated patients. **Pre-Cyclophosphamide infusion** ☐ 1.5 liters of D5 1/2NS at _____ml/hour (150ml/M²/hour) Other: _____ **Intra-Cyclophosphamide infusion** ☐ 1 liter D5 1/2NS at _____ml/hour (150ml/M²/hour) Other: _____ **Post- Cyclophosphamide infusion** ☐ 1.5 liters of D5 1/2NS at _____ml/hour (150ml/M²/hour) Other: _____
		Medications (Routine): **Antiemetics:** ☐ Ondansetron (Zofran) 8mg IVP 30 minutes prior to Cyclophosphamide infusion ☐ Ondansetron (Zofran) 8mg IVP 3 hours post-Cyclophosphamide infusion ☐ Repeat Ondansetron (Zofran) 8mg IVP _____ hours and _____ hours after Cyclophosphamide infusion initiated. ☐ Dexamethasone (Decadron) 10mg PO 3 hours post-Cyclophosphamide infusion Other: _____ **Diuresis:** ***Choose One:*** ☐ Furosemide (Lasix) _____mg IVP x1 with Cyclophosphamide infusion ☐ Furosemide (Lasix) _____mg PO x1 with Cyclophosphamide infusion ☐ Furosemide (Lasix) _____mg IVP x1 one hour post- Cyclophosphamide infusion **Infusion:** **House officer or Chemotherapy Certified Nurse must hang Cyclophosphamide.** Actual weight: _____ Height: _____ BSA: _____ ☐ Cyclophosphamide (Cytoxan) _____ grams (_____ gram/M²) IVPB over 4 hours for _____ (indication) ***Change IV tubing of back up fluid after completion of Cyclophosphamide for myopathy.** **Other:** ☐ Mesna (Mesnex)_____mg IVPB x1 with Cyclophosphamide infusion, bladder protection ☐ Repeat Mesna (Mesnex) _____mg IVPB 3 hours post-Cyclophosphamide infusion _____
		Attending MD: _____ _____ Telephone # / Pager #_____ SIGNATURE REQUIRED PRINTED NAME REQUIRED MD: _____ _____ Telephone # / Pager #_____ SIGNATURE REQUIRED PRINTED NAME REQUIRED

DO NOT WRITE BELOW THIS LINE