

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

**DO NOT WRITE BELOW THIS LINE**

