

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

- | | |
|--|--|
| <input type="checkbox"/> NL Infusion Care, AR Gould, Presque Isle
Phone: 207-768-4589; Fax: 207-768-4183 | <input type="checkbox"/> NL Mary Dow Center, Ellsworth
Phone: 207-664-5584; Fax: 207-664-5485 |
| <input type="checkbox"/> NL Infusion Care, Blue Hill
Phone: 207-374-3995; Fax: 207-374-3970 | <input type="checkbox"/> NL Infusion Care, Mayo, Dover-Foxcroft
Phone: 207-564-4254; Fax: 207-564-4418 |
| <input type="checkbox"/> NL Infusion Care, CA Dean, Greenville
Phone: 207-695-5222; Fax: 207-695-4801 | <input type="checkbox"/> NL Mercy Cancer Care, Portland
Phone: 207-553-6868; Fax: 207-904-0917 |
| <input type="checkbox"/> NL Infusion Care, Brewer
Phone: 207-973-9785; Fax: 207-973-9788 | <input type="checkbox"/> NL Infusion Care, SVH, Pittsfield
Phone: 207-487-4052; Fax: 207-487-3995 |
| <input type="checkbox"/> NL Infusion Care, Waterville
Phone: 207-861-3380; Fax: 207-861-3348 | |

**OUTPATIENT CYCLOPHOSPHAMIDE
(CYTOXAN) ORDERS**

Page 1 of 1

Diagnosis: _____ **ICD10:** _____

IV Access:

- ☐ Saline Lock:
- ☒ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
 - ☒ Discontinue Saline Lock after therapy completed
- ☐ PICC Line:
- ☒ Routine PICC Line Care, labs and restoration
 - ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
- ☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☒ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg **BSA:** _____ m²

Labwork: Repeat prior to each scheduled cyclophosphamide (Cytoxan) infusion (within 7 days prior to treatment)

- ☒ CBC with Differential Treat if: ANC greater than or equal to _____
- ☒ Comprehensive Metabolic Panel Platelets greater than or equal to _____

Medication:

Pre-hydration & Pre-medication

- ☒ Sodium Chloride 0.9%, IV, ONCE
 - ☐ Tot Vol: 500 mL, Flow Rate: 500 mL/hr, Soln, IV, Infuse over 1 hour
 - ☐ Tot Vol: 1000 mL, Flow Rate: 1000 mL/hr, Soln, IV, Infuse over 1 hour
- ☐ Other: _____

- ☒ Palonosetron (Aloxi) 0.25 mg, Soln, IVPB, ONCE
- ☒ Dexamethasone (Decadron) 12 mg, Tab, PO, ONCE

Medication

- ☐ Cyclophosphamide (Cytoxan) _____ mg/m² = _____ mg/250 mL Sodium Chloride 0.9%, Soln, IVPB, ONCE, Infuse over 60 minutes
- OR**
- ☐ Cyclophosphamide (Cytoxan) _____ mg/kg = _____ mg/250 mL Sodium Chloride 0.9%, Soln, IVPB, ONCE, Infuse over 60 minutes

Post-hydration

- ☐ Sodium Chloride 0.9%, IV, ONCE
 - ☐ Tot Vol: 500 mL, Flow Rate: 500 mL/hr, Soln, IV, Infuse over 1 hour
 - ☐ Tot Vol: 1000 mL, Flow Rate: 1000 mL/hr, Soln, IV, Infuse over 1 hour
- ☐ Other: _____

Subsequent dosing

Repeat: ☐ Every _____ weeks ☐ Every _____ months **Duration:** _____ ☐ Doses/Times ☐ Weeks ☐ Months

Other: _____



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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
June 2024 (Header updated and removed reference to Policies)