Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Cytoxan Infusion Order (Revised 4/3/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: Creatinine, LFTs, and Urinalysis prior to starting Cytoxan. (If outside of Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Cytoxan (cyclophosphamide) _____ mg IV over 30 minutes (or over 1 hour for doses > 2gm)

Frequency: _____

ICD 10 code: _____

Pre-Medications:

Administer in the following order:

- Normal Saline 0.9% 250mL over 30 minutes
- Zofran 8mg IV x 1
- Mesna _____ mg (150mg/m²) IV over 30 minutes

Post-Cytoxan Medications:

Administer in the following order:

- Normal Saline 0.9% 250mL over 30 minutes
- Mesna _____ mg (150mg/m²) IV over 30 minutes

PRN Medications:

- Acetaminophen 500mg PO q4 hours PRN pain
- Zofran 4mg IVP q4 hours PRN nausea/vomiting
- Ibuprofen 800mg PO q8 hours PRN pain

Additional Orders:

_____

Special Instructions:

- Patient must have a CBC with diff, LFTs, and Urinalysis every 2 weeks or 10 days after each infusion
  - Do not infuse if ANC is less than 1500
  - Do not infuse if platelets are less than 50,000
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs on arrival, pre- and post- Cytoxan infusion, and prior to discharge. Obtain vital signs PRN during infusion.
- Encourage patient to force fluids (8oz) and empty bladder every 2 hours while awake for 24 hours post infusion.

Provider Name: _____
Provider Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: