Atrium Health

Atrium Health Infusion Centers

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Cytoxan® (cyclophosphamide) Infusion Order (Revised 10/14/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis:

☐ ICD-10:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Patient has signs and symptoms of an active infection within the last 48 hours.
- Patient has noticed hematuria after previous treatment.

☑ Hold treatment and notify provider IF:
- ANC LESS THAN 1,500;
- Platelets LESS THAN 50,000;
- LFTs ABNORMAL or not on file;
- Serum Creatinine ABNORMAL or not on file;
- Urinalysis ABNORMAL or not on file.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Obtain vital signs upon arrival, PRIOR to treatment, PRN during treatment, POST treatment and PRIOR to discharge.
☑ Encourage patient to force fluids (8oz) and empty bladder every 2 hours while awake for 24 hours POST infusion.

Hydration:

☐ Sodium Chloride (bolus) 0.9% 250mL IV over 30 minutes

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Ondansetron (Zofran) 8mg IV over at least 1 minute ONCE. Administer after saline hydration.
☐ Mesna (Mesnex) 150mg/m2 IV over 30 minutes ONCE. Administer after Ondansetron.

Infusion Therapy:

☑ Cyclophosphamide (Cytoxan) _____mg IV over 30 minutes.

Post -Medications

☐ Sodium Chloride (bolus) 0.9% 250mL IV over 30 minutes.
☐ Mesna (Mesnex) 150mg/m2 IV over 30 minutes ONCE.

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 500mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: