INTRAVENOUS CYCLOPHOSPHAMIDE

(PHYSICIAN ORDER SHEET)

[To be kept in Patient's Cyclophosphamide File]

Based on NIH, EURO-LUPUS & EUVAS Vasculitis Protocol

Adapted by Dr Ramani Rheumatology Clinic

Date:

PRE-INFUSION CHECKLIST

Assess signs and symptoms of infection, fever, surgery, etc. (Contact physician if any issues)

NON-MEDICATION ORDERS

VITALS:

☐ **Weight** _____ **kg**

☐ **Vital signs at baseline**

☐ **Vital signs every** _____ **mins**

Recommendation: every 30 minutes during infusion and for 30 minutes after infusion.

If there is a history of infusion reaction, monitor vital signs every 10 minutes for 30 minutes, then every 30 minutes.

BLOOD WORKS

INFUSION DAY

- **Before infusion**

> FBC, Platelets, Renal profile (Creatinine), Urine.

- _____
- _____

DAY-10 (AFTER CYCLE)

• FBC, platelets, Renal profile (Creatinine), Urine

- _____
- _____

Physician signature & stamp:

PATIENT'S DATA

Name: _____

MRN: _____

Ward 10B Bed: _____ **/ Daycare**

Drug allergy:

MEDICATION ORDERS (Please tick appropriate boxes)

Cyclophosphamide Regimen

(Cyclophosphamide is available in 500 mg/vial)

Please tick in appropriate boxes.

Recommend: 3-6 doses depending on disease type, severity & response.

☐ **EURO-LUPUS PROTOCOL**

IV cyclophosphamide 500 mg + Mesna 200 mg every 2 weeks for _____ **doses**

☐ **NIH PROTOCOL (Dose: 500-1000 mg/m2)**

IV cyclophosphamide _____ **mg + Mesna 200 mg monthly for** _____ **doses**

☐ **EUVAS VASCULITIS PROTOCOL (Dose: 15 mg/kg [Max: 1200 mg])**

(Tablet Bactrim for PCP prophylaxis while on treatment regimen)

IV cyclophosphamide _____ **mg + Mesna 200 mg**

☐ **Every 2 weeks for 3 doses; then...**

☐ **1st Dose** ☐ **2nd Dose** ☐ **3rd Dose**

☐ **Then, every 3 weeks. Once in remission, continue another 3 months.**

☐ **Others: IV cyclophosphamide** _____ **mg** _____

_____

Cyclophosphamide Preparation and Administration

STAT dose order form has to arrive at pharmacy before 10am on day of preparation of patients infusion day.

☐ **Infuse IV Cyclophosphamide over** _____ **(2) hours.**

(Rate: _____ **(250)mL/hr)**

Hydration

☐ **Normal saline 0.9%** _____ **mL IV over** _____ **hour(s), start 1 hour before IV Cyclophosphamide infusion.**

☐ **Normal saline 0.9%** _____ **mL IV over** _____ **hour(s), after IV infusion completed.**

Pre/Post-Medication

(i.e. Metoclopramide, Dexamethasone)

☐ **Pre / Post** _____

☐ **Pre / Post** _____

INFUSION-RELATED REACTION

STOP the infusion immediately and notify the prescriber.

IV Cyclophosphamide Infusion Chart

Note: Add IV Mesna 200 mg into the cyclophosphamide drip.

Date: _____

Name: _____

MRN: _____

Weight: _____

Dose: _____

Infusion Monitoring

Duration			Vitals Monitoring			Adverse Reactions				
Time	Mins	Dose	B/P	PR	Temp	Nausea / Vomiting	Abdominal pain	Diarrhoea	Throat irritation	Lethargy
	0									
	30									
	60									
	90									
	120									
	180									

Clinical notes / action taken: