



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

Main Office Phone 315-472-7504

Nurse Navigator Phone 315-506-2469

Main Fax 315-634-5168

**Cytosan (Cyclophosphamide) Non-Oncology Treatment Order Set**

1. Patient Name: \_\_\_\_\_

2. DOB: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**3. Diagnosis:**

Primary ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

Other ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

**4. Pre-medications:**

Aloxi: 250 mg IVP

Granisetron: 1mg IVP

Dexamethasone: 10mg IV

Mesna: \_\_\_\_\_

Other Pre-medication: \_\_\_\_\_

No Pre-medications indicated

**5. Drug Order:**

**Cytosan (Cyclophosphamide)** *Ok to substitute with generic/biosimilar*

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

IV Hydration Orders: \_\_\_\_\_

New to Therapy

Continuing therapy: Last Dose Received \_\_\_\_\_ Next Dose Due \_\_\_\_\_

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

CBC & CMP within 2 weeks prior to infusion

Other: \_\_\_\_\_

No lab monitoring indicated

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*

*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

**7. Required Baseline Lab/Testing have been completed:**

CBC/CMP, date: \_\_\_\_\_  Other: \_\_\_\_\_  None

**8. Patient Assistance & REMS Program Enrollment**

Yes, patient has been enrolled in \_\_\_\_\_ program. (Provide Copy Enrollment Forms)

No, patient has not been enrolled in any programs.

7. Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This drug administration order form is valid for 12 months)*