MRN:____________________

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:____________________

STANDARD CYCLOPHOSPHAMIDE PLAN OF TREATMENT

(Re) Certification Period From________________________to ________________________

NOTE: Patient ***may be ineligible*** to receive cyclophosphamide if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, unable to adequately hydrate, or planned/recent surgery.

1. Patient Name: ____________________________________Height (inches): _____Weight (lbs):_____

2. Allergies: ____

3. Diagnosis: ☐ Primary ICD-**10 Code:** ________**Diagnosis description:** ________________________

☐ Secondary **ICD-10 Code:** ________**Diagnosis description:**________________________________

4. Pre-medications: ☐ None ***OR Administered 30 minutes prior to infusion as selected:***

Acetaminophen:	Ondansetron: ☐ 4 mg PO, ☐ 4 mg IV, ☐ 8 mg PO, or ☐ 8 mg IV. May repeat x ____
☐ 650 mg PO	☐ 10 mg/50 ml Sodium Chloride IV over 15-30 minutes
☐ 500 mg PO	☐ Dexamethasone 10 mg IV over 15-30 mins or other _____mg IV
☐ 325 mg PO	Mesna ______ mg over ______ minutes IV prior to infusion

Pre-medicate with other: ____

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Check for blood return prior to start of Cyclophosphamide and utilize Hazardous Drug Precautions.

5. Orders: ☐ Cyclophosphamide ____ mg in ____ ml of Sodium Chloride 0.9% IV to infuse over ____ minutes
☐ Pre- hydration: Infuse ____ ml Sodium Chloride 0.9% IV over ____ hours before Cyclophosphamide
☐ Post- hydration: Infuse ____ ml Sodium Chloride 0.9% IV over ____ hours after Cyclophosphamide
☐ Encourage oral hydration of ______________________ after infusion

6. Frequency: Orders to be completed every ____ week (s) x _____ month(s)

Special Orders: ____

Clinical lab monitoring required: CBC results required 7-10 days after each infusion. Next treatment will be held for WBC level less than 2.5 K/uL. The referring MD office will be notified, and treatment will not be resumed until MD clearance received.

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

7. Physician's Signature: ___________________________/ ________________________Date: _______________
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: ____NPI: ____________________

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 5/25/18

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Guidelines for Prescribing Cyclophosphamide

(Required documentation with all initial referrals)

Patient Name: ____ **Referral Date:**____________________

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Cyclophosphamide as specified of ________ weeks. Last known biological therapy: _____________ and last date received:____________. (Include copy of last infusion record if available and currently on therapy)

___ Other as requested: ____
____

Pre-Screening:

___ **CBC results within last 30 days required prior to start of therapy.**

** Warnings/Precautions: **Serious Infections, Myelosuppression, Immunosuppression, & Bone Marrow Failure:** Severe Immunosuppress can occur, patients should not have any active ongoing infections or wound. **Close hematological monitoring is required. Urinary Tract & Renal Toxicity:** Urinary outflow obstruction is a contraindication to therapy. Hemorrhagic cystitis, pyelitis, ureteritis, and hematuria can occur. **Cardiotoxicity:** Myocarditis, myopericarditis, pericardial effusion, arrhythmias, and congestive heart failure have been reported. **Pulmonary Toxicity:** Pneumonia, pulmonary fibrosis, & pulmonary veno-occusive disease may occur. Secondary malignancies. **Liver Disease:** Veno-occlusive disease may occur. **Female & Male reproductive potential:** Counsel patients on pregnancy prevention and planning advised. **Aggressive Hydration is suggested and monitoring for hyponatremia advised.**
See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.