Palmetto INFUSION®

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

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Cyclophosphamide Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐	See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ _____- Other:_____

☐ _____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	CBC results within 30 days		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED.

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

IV	Diphenhydramine	◯ 25mg	◯ 50mg					
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:				
	Famotidine	◯ 20mg	◯ 40 mg					
	Dexamethasone	◯ 10mg IV over 15 -30min						
	Ondansetron	◯ 4mg	◯ 8mg					
	Mesna	◯ _____mg over ____ minutes						
	Other:	◯						

PO	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg
	Famotidine	◯ 20mg	◯ 40mg		
	Diphenhydramine	◯ 25mg	◯ 50mg		
	Fexofenadine	◯ 60mg	◯ 180mg		
	Cetirizine	◯ 10mg			
	Loratadine	◯ 10mg			
	Ondansetron	◯ 4mg	◯ 8mg		
	Other:	◯			

MEDICATION/DOSE:

☑ Cyclophosphamide _____mg in _____ml of NS given IV over _____ minutes.

◯ Pre-Hydration: _____ml NS IV over _____ hours prior to cyclophosphamide.

◯ Post-Hydration: _____ml NS IV over _____ hours after cyclophosphamide.

◯ Encourage oral hydration of _____ml after infusion.

FREQUENCY:

◯ Every _____ weeks x _____ months

◯ Other: _____

SPECIAL/LAB ORDERS:

◯ _____

_____

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

CBC results required 7-10 days after each infusion

WBC < 2.5 K/uL: MD will be notified and dose will be held unless written clearance is provided by MD

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	