

COREWELL HEALTH INFUSION CENTERS

CYTOXAN NON-ONCOLOGIC PRESCRIPTION

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:		Date of Birth:	Medical Record #:
Physician Name:	Address:		Office #:
Diagnosis:		Diagnosis Code (ICD-10):	

PATIENT INFORMATION		
Please attach these <u>required</u> documents to Prescription (if not in EPIC): <input checked="" type="radio"/> Copy of Insurance Card <input checked="" type="radio"/> Labs <input checked="" type="radio"/> Supporting clinical documentation <input checked="" type="radio"/> Patient Demographics <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies: _____		
Height: _____ ft _____ in	Weight: _____ kg / lbs	Date: _____

MEDICATION	DOSE	# Doses
CYCLOPHOSPHAMIDE (CYTOXAN)	<input type="checkbox"/> Cytoxan _____ mg IVPB over 30 minutes every _____ weeks <ul style="list-style-type: none"> • Baseline CBC with differential and CMP needed prior to appointment. <input type="checkbox"/> Mesna _____ mg 30 minutes prior to Cytoxan infusion and 4 hours after Cytoxan infusion (2 doses) <ul style="list-style-type: none"> • Each Mesna dose is equal to 20% of the daily Cytoxan dose. <input type="checkbox"/> Sodium chloride 0.9% _____ mL IV over _____ hours pre-hydration <input type="checkbox"/> Sodium chloride 0.9% _____ mL IV over _____ hours post-hydration <input type="checkbox"/> Zofran _____ mg IV 30 minutes prior to Cytoxan infusion	
<ul style="list-style-type: none"> • Adult Anaphylaxis Protocol • Notify physician if reaction occurs 		

Physician Signature _____ Beeper # _____ Date _____ Time _____