BEAUMONT 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 : 313-593-8551** ☐ **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 *required* documents to Prescription (if not in EPIC): • Copy of Insurance Card • Labs • Supporting clinical documentation • Patient Demographics ☐ **NKDA** ☐ **Drug Allergies:** _____
Height: _____ ft _____ in **Weight:** _____ kg / lbs **Date:**_____

MEDICATION	**DOSE**	**# Doses**
CYCLOPHOSPHAMIDE (CYTOXAN)	☐ Cytoxan _____ mg IVPB over 30 minutes every _____ weeks • **Baseline CBC with differential and CMP needed prior to appointment.** ☐ Mesna _____ mg 30 minutes prior to Cytoxan infusion and 4 hours after Cytoxan infusion (2 doses) • **Each Mesna dose is equal to 20% of the daily Cytoxan dose.** ☐ Sodium chloride 0.9% _____ mL IV over _____ hours pre-hydration ☐ Sodium chloride 0.9% _____ mL IV over _____ hours post-hydration ☐ Zofran _____ mg IV 30 minutes prior to Cytoxan infusion	
• Adult Anaphylaxis Protocol • Notify physician if reaction occurs		

Physician Signature _____Beeper # _____ Date _____ Time_____