BCRenal
an agency of the Provincial Health Services Authority

CYCLOPHOSPHAMIDE INFUSION PROTOCOL
For Glomerulonephritis

Rev: May/15

PATIENT INFORMATION

Name: _____

Address: _____

PHN: _____

✹ Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

- ✹ **Admit to medical short stay under Dr.** _____
- ✹ **Insert IV into dominant arm, or if arteriovenous fistula or graft present, then opposite arm**
- ✹ **Vital signs x 1, then PRN**

LABORATORY:

- ✹ CBC with differential, serum creatinine, BUN, electrolytes
- ☐ Other: _____

ANTIEMETICS:

- ☐ **ONDANSETRON** 4 mg IV 30 min prior or 8 mg PO 1 hour prior to treatment
- ☐ Other: _____

- ☐ **ONDANSETRON** 4 mg IV or 8 mg PO x 1 PRN for nausea during infusion
- ☐ Other: _____

HYDRATION:

- ☐ NaCl 0.9% 1000 mL IV over 3 hours, start 1-hour prior to start of infusion
- ☐ NaCl 0.9% _____ mL IV over _____ hour(s), start _____ hour(s) prior to start of infusion
- ☐ Other: _____

AND

- ☐ Encourage patient to have good oral fluid intake after the treatment of at least 2 L in 24 hours

CYCLOPHOSPHAMIDE DOSE

NIH protocol:

- ☐ **CYCLOPHOSPHAMIDE** 500 to 1000 mg/m² x _____ m² = _____ mg IV

Recommended dosing schedule for the NIH protocol:	
eGFR less than 30 ml/min/1.73 m² OR age over 70 years	Reduce dose by 25%
eGFR less than 30 ml/min/1.73 m² AND age over 70 years	Reduce dose by 50%
WBC nadir < 3.5 x 10^9/L	Reduce subsequent doses by 25%

Body Surface Area (BSA) calculation:	
Height: _____ cm	Actual weight: _____ kg
$BSA(m^2) = \sqrt{\frac{Height(cm) \times Weight(kg)}{3600}}$	**BSA** = _____ m² • Round to 2 decimal places

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EUVAS vasculitis protocol: ☐ **CYCLOPHOSPHAMIDE** _____ mg/kg x _____ kg = _____ mg (Max 1.2 g per dose) IV

Recommended dosing schedule for the EUVAS protocol:		
Age (years)	eGFR greater than 30 ml/min/1.73 m^2	eGFR less than or equal to 30 ml/min/1.73 m^2
Less than 60	15 mg/kg	12.5 mg/kg
Between 60 and 70	12.5 mg/kg	10 mg/kg
Greater than 70	10 mg/kg	7.5 mg/kg

EURO-LUPUS protocol: ☐ **CYCLOPHOSPHAMIDE** 500 mg IV

Other: ☐ **CYCLOPHOSPHAMIDE** _____ mg IV

CYCLOPHOSPHAMIDE FREQUENCY

NIH protocol: ☐ monthly x _____ doses (Recommend: 3 to 6 doses depending on disease type, severity, and response)

EUVAS vasculitis protocol: ☐ q2 weeks x 3 doses, then q3weeks x _____ more doses (Recommend: a minimum of 3 more doses for a total of 4 months to a maximum of 6 more doses for a total of 6 months; total duration depends on response)

EURO-LUPUS protocol: ☐ q2weeks x 6 doses

Other: ☐ _____

Cylophosphamide to be given on the following dates:

Dose 1: _____	Dose 5: _____	Dose 9: _____
Dose 2: _____	Dose 6: _____	Dose 10: _____
Dose 3: _____	Dose 7: _____	Dose 11: _____
Dose 4: _____	Dose 8: _____	Dose 12: _____

✹ **Remove IV**

✹ **Discharge home**

Fax completed order to medical day care (Fax #_____)

and to renal pharmacist (Fax # _____)

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