BCRenal
Provincial Health Services Authority

CYCLOPHOSPHAMIDE INFUSION PROTOCOL
For Glomerulonephritis

Rev: Aug/23

PATIENT INFORMATION

Name: _____

Address: _____

PHN: _____

Phone number: _____

✹ 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

ANTIEMETICS:

☐ **ondansetron** 4 mg IV x 1 dose 30MIN prior to treatment

OR

☐ **ondansetron** 8 mg PO x 1 dose 60MIN prior to treatment

☐ **ondansetron** 4 mg IV x 1 dose PRN for nausea during infusion

OR

☐ **ondansetron** 8 mg PO x 1 dose PRN for nausea during infusion

HYDRATION:

☐ sodium chloride 0.9% 1000 mL IV over 3 hours, start 1-hour prior to start of infusion

☐ _____ (fluid) _____ mL IV over _____ hour(s), start _____ hour(s) prior to start of infusion

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/m^2 x _____ m^2 = _____ mg IV

Recommended dosing schedule for the NIH protocol:	
eGFR less than 30 ml/min/1.73 m^2 OR age over 70 years	Reduce dose by 25%
eGFR less than 30 ml/min/1.73 m^2 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** = _____ m^2 • Round to 2 decimal places

DATE (DD/MM/YYYY)	PRESCRIBER NAME (PRINTED)	PRESCRIBER SIGNATURE	COLLEGE ID	CONTACT NUMBER

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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: ☐ Q2weeks 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

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: _____

If a patient is receiving hemodialysis (HD), cyclophosphamide is to be given either post-HD or on non-HD days.

✹ Remove IV

✹ Discharge home

Fax completed order to:
Medical Day Care (fax number:)
Renal pharmacist (fax number:)

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