BCRenal
Provincial Health Services Authority

Membranous Nephropathy: CYCLOPHOSPHAMIDE PROTOCOL Modified Ponticelli Regimen

Rev: Jan/19

PATIENT INFORMATION

Name: _____

Address: _____

PHN: _____

Phone number: _____

DRUG AND FOOD ALLERGIES

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

To obtain cyclophosphamide coverage under the BCR GN Formulary:

- ✹ Ensure the patient is registered in PROMIS, or if already registered, ensure address and phone number are accurate for medication delivery
- ✹ Fax this prescription along with an application form to Macdonald's Pharmacy at **1-866-685-0305**

1. 6-month corticosteroid and cyclophosphamide protocol (modified Ponticelli regimen):

Month 1, 3 and 5:

- ✹ **methylPREDNIsone** IV x 3 days at the beginning of months 1, 3 and 5 (follow medical short stay orders on page 3)
- ✹ Then **predniSONE** 0.5 mg/kg _____ mg (max 30 mg) PO daily for approximately 27 days (i.e. for the remainder of the 1 month period) to be given on:

  (Month 1 dates) _____ to _____
  (Month 3 dates) _____ to _____
  (Month 5 dates) _____ to _____

☐ At the end of month 1, 3 and 5 taper off **predniSONE** by reducing the dose by 5 mg per day until the patient reaches a total daily dose of 10 mg; then reduce the dose by 2.5 mg per day until off.

Month 2, 4 and 6:

- ✹ **cyclophosphamide** (recommend: 2 mg/kg/day, round to nearest 25 mg) _____mg (usual max 175 mg) PO daily every morning with plenty of water throughout the day, for approximately 30 days during months 2, 4 and 6. On the following dates:

  (Month 2 dates) _____ to _____
  (Month 4 dates) _____ to _____
  (Month 6 dates) _____ to _____

Recommended cyclophosphamide dosing schedule	
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 less than 3.5 x 10^9/L	Hold until WBC recovers and reduce subsequent doses by 25%

Quantities: Fill entire quantity

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The prescriptions on this page can be filled at any community pharmacy.

2. Osteoporosis prevention while on the modified Ponticelli regimen:

calcium: The recommended daily intake is 1000 mg (19 to 50 years old) to 1200 mg of elemental calcium (over 50 years old). Supplement as necessary to reach this target.

☐ **calcium carbonate** 1250 mg (500 mg elemental) 1 tab PO daily
☐ **calcium carbonate** 1250 mg (500 mg elemental) _____ tabs PO _____

vitamin D: The recommended daily intake is 600 units (1 to 70 years old) to 800 units (over 70 years old). Supplement as necessary to reach this target:

☐ **vitamin D_3** 400 units PO daily
☐ **vitamin D_3** _____ units PO daily

alendronate: Is recommended in patients with a history of fragility fracture or an established diagnosis of osteoporosis, in postmenopausal women, in men greater or equal to 50 years old, or in patients greater or equal to 30 years old where the initial predniSONE dose is greater or equal to 30 mg/day and who have been exposed to over 5 grams of predniSONE in the previous year. Additional patients may also qualify based on their FRAX score (see Supporting Evidence).

☐ **alendronate** 70 mg PO weekly
☐ _____ mg PO _____

3. GI prophylaxis while on the modified Ponticelli regimen:

☐ **ranitidine** 150 mg PO BID
☐ **ranitidine** 150 mg PO daily if eGFR less than 50 ml/min/1.73 m^2
☐ **pantoprazole magnesium** 40 mg PO daily (note: special authority required)

4. *Pneumocystis jiroveci* prophylaxis while on the modified Ponticelli regimen:

☐ **sulfamethoxazole-trimethoprim (e.g. SEPTRA SS)** 400/80 mg 1 tab PO daily
☐ **sulfamethoxazole-trimethoprim (e.g. SEPTRA DS)** 800/160 mg 1 tab PO 3x/week
☐ **sulfamethoxazole-trimethoprim (e.g. SEPTRA SS)** 400/80 mg 1 tab PO 3x/week if eGFR less than 30 ml/min/1.73 m^2
☐ **dapsone** 100 mg PO daily (for patients who cannot tolerate sulfamethoxazole-trimethoprim; monitor for hemolysis and test for G6PD deficiency)
☐ _____ mg PO _____

Quantities: New prescription fill quantity shall be for 90 days and if tolerated, may repeat times one. It is recommended that calcium and vitamin D be purchased over the counter.

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

✹ **Admit to medical short stay under Dr.** _____

✹ **Insert IV in dominant arm, or if arteriovenousfistula or graft present, then opposite arm**

✹ **Vital signs x 1, then as required**

☐ **methylPREDNIsone** 1000 mg IV x 3 days at the beginning of months 1, 3 and 5
☐ **methylPREDNIsone** _____ mg IV x 3 days at the beginning of months 1, 3 and 5

The patient is to receive the above **methylPREDNIsolone** doses on the following consecutive dates:

Month 1: _____
Month 3: _____
Month 5: _____

✹ **Remove IV**

✹ **Discharge home**

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REQUEST FOR LABORATORY SERVICES
For membranous nephropathy patients on cyclophosphamide

Rev: Jan/19

PATIENT INFORMATION

Name: _____

Address: _____

PHN: _____

Phone number: _____

DRUG AND FOOD ALLERGIES

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

INSTRUCTIONS:

✹ Complete the following blood work at **baseline** (at the start of month 1 and 2) and then **after every week** during the 1st month of **cyclophosphamide** (during month 2), on the following dates:

(Month 1 baseline date): _____ (Month 2 baseline date): _____

(Month 2 week 1 date): _____ (Month 2 week 2 date): _____

(Month 2 week 3 date): _____ (Month 2 week 4 date): _____

Note: Subsequent blood work frequency during months 3 to 6 should be based on tolerability and safety during months 1 and 2, and should be ordered as clinically indicated.

LABORATORY TESTS:

✹ CBC with differential, creatinine, urea, sodium, potassium, bicarbonate, chloride

✹ AST, ALT, ALP, GGT, total bilirubin

Additional tests:

_____

_____

_____

_____

_____

Distribute results to all those ticked below:

☑	Ordering Nephrologist:
☐	Copies to:
☑	**Computer Download PROMIS** (BC Bio-Med LEAD4, LifeLabs H0762)

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