# Cyclophosphamide Pulsed (Euro-lupus Nephritis Protocol)

Cyclophosphamide 500 mg day 1 every 2 weeks for 6 cycles (Fixed dose)

Attach label and sign, or complete

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Cycle Number | | Date of last cycle / / | Height | | Weight | | BSA | | | Allergies | |
| May proceed with doses as written if on day of treatment : Hb ≥ 100 ANC≥1.5 x 109/L, Platelets≥100 x 109/L, *or*OK to proceed with out of range bloods (sign):  Confirmation to proceed with treatment has been received **Y N** | | | | | | | | | | | |
| *Date to be Given* | *Medication* | | | *Dose & Route* | | *Date Given* | | *Time*  *Given* | *Given by* | | *Checked by* |
| / / | Granisetron 30mins prior to treatment | | | 2 mg PO | |  | |  |  | |  |
|  | Dexamethasone 30mins prior to treatment | | | 8 mg PO | |  | |  |  | |  |
|  | Normal Saline 100 mL over 15 mins | | |  | |  | |  |  | |  |
|  | Cyclophosphamide IV in 100 mL NS over 30 min  500 mg | | | 500mg IV | |  | |  |  | |  |
|  | Mesna 500mg (equal to Cyclophosphamide dose) in 500mL NS over 30mins *if patient has experienced bladder symptoms* | | | IV | |  | |  |  | |  |
|  | Normal Saline 100 mL over 15min | | |  | |  | |  |  | |  |
|  | Metoclopramide (To Take Home) | | | 10 mg QID | |  | |  |  | |  |
|  | Granisetron (To Take Home) D2,D3 | | | 2 mg PO | |  | |  |  | |  |
|  |  | | |  | |  | |  |  | |  |
| For First Dose Consultant to confirm Dosage: Name / Pager Signature | | | | | | | | | | | |
| Printed Prescriber Name / Pager Prescriber signature Date | | | | | | | | | | | |