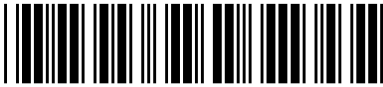




Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)
For Hepatitis C

Page 1 of 2

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. This order should be used for patients receiving peginterferon alfa-2a (PEGASYS) or peginterferon alfa-2b (PEGINTRON).
3. Round G-CSF to nearest syringe size when possible
 - a. 300 mcg for patient weight between 40 kg and 75 kg
 - b. 480 mcg for patient weight ≥ 75 kg

LABS:

- CBC with differential, Routine, ONCE, prior to therapy
- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- Labs already drawn. Date: _____

MEDICATIONS:

filgrastim-sndz (ZARXIO) injection, subcutaneous, ONCE

- 300 mcg
- 480 mcg
- Other: _____ (*Pharmacist will round dose to nearest vial or syringe combination and modify during order verification*)

Interval: (must check one)

- Once
- Once a week x _____ doses. Administer on _____ day of week as it relates to peginterferon
- Twice a week x _____ doses
- Three times per week x _____ doses

NURSING ORDERS:

1. TREATMENT PARAMETERS – Continue treatment until absolute neutrophil count (ANC) is greater than or equal to 1000/mm³. Contact prescriber for additional orders if needed.
2. Prior to drawing a new CBC with differential, verify whether or not patient has had labs drawn since the time of last medication administration
3. Please schedule G-CSF to be given 24 hours before or 24-48 hours after peginterferon therapy if possible.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declothing (alteplase), and/or dressing changes.



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Page 2 of 2

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

Beaverton

OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

NW Portland

Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

Gresham

Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

Tualatin

Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders