ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)

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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 not be used for mobilization dosing. Please see “Filgrastim-sndz (G-CSF) for Stem Cell Mobilization” order form
3. Do NOT administer filgrastim-sndz within 24 hours before or after radiation or chemotherapy.
4. 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 is ≥75 kg
   c. 5 mcg/kg/dose for patient weight is ≤ 40 kg. Pharmacy will send exact dose.
   d. For other doses, pharmacy will round to nearest syringe combination and modify during order verification.

LABS: (must check one)
☐ CBC with differential, Routine, ONCE prior to therapy and every ________
  (visit)(days)(weeks)(months) – Circle One
☐ Labs already drawn. Date: __________

MEDICATIONS: (must check one)
1. Doses for patients > 40 kg:
   ☐ filgrastim-sndz (ZARXIO) injection 300 mcg/0.5 mL subcutaneous, ONCE
   ☐ filgrastim-sndz (ZARXIO) injection 480 mcg/0.8 mL subcutaneous, ONCE
2. Dose for patients ≤ 40 kg:
   ☐ filgrastim-sndz (ZARXIO) injection 5 mcg/kg/dose subcutaneous, ONCE
3. Other dose:
   ☐ filgrastim-sndz (ZARXIO) injection _________ subcutaneous, ONCE (Pharmacist will round dose to nearest vial or syringe combination and modify during order verification)
4. Interval: (must check one)
   ☐ Once
   ☐ Once daily x _____ doses
   ☐ Once a week x _____ doses
   ☐ Twice a week x _____ doses
   ☐ Three times per week x _____ doses
   ☐ Daily until ANC > ________
NURSING ORDERS:
1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Prior to drawing a new CBC with differential, verify if patient has had recent labs drawn.
3. Continue treatment until ANC is greater than or equal to ________/mm$^3$ for ____ consecutive days. Contact prescriber for additional orders if needed.
4. If patient has received radiation or chemotherapy within 24 hours of administration, contact provider for guidance.

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: ______________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:
☐ Beaverton  ☐ NW Portland
OHSU Knight Cancer Institute  Legacy Good Samaritan campus
15700 SW Greystone Court  Medical Office Building 3, Suite 150
Beaverton, OR 97006  1130 NW 22nd Ave.
Phone number: 971-262-9000  Portland, OR 97210
Fax number: 503-346-8058  Phone number: 971-262-9600

☐ Gresham  ☐ Tualatin
Legacy Mount Hood campus  Legacy Meridian Park campus
Medical Office Building 3, Suite 140  Medical Office Building 2, Suite 140
24988 SE Stark  19260 SW 65th Ave.
Gresham, OR 97030  Tualatin, OR 97062
Phone number: 971-262-9500  Phone number: 971-262-9700
Fax number: 503-346-8058  Fax number: 503-346-8058

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