



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

PO7071



ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)

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 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 > _____



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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 _____/mm³ 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

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