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

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, declotting (alteplase), and/or dressing changes.
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