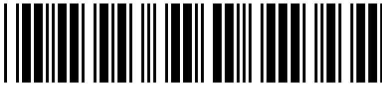
Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER

Filgrastim-sndz (ZARXIO)
For Hepatitis C

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 $1000/mm^3$. 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.

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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 # _________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; 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:**_____________

<u>OLC Central Intake Nurse:</u>

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