ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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 is greater than or equal to _____/mm3 for __ consecutive days.
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 \( \text{____}_\text{mm}^3 \) 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
   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