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 is greater than or equal to _____/mm3 for __ consecutive days.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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**: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Central Intake:

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