ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)
For Stem Cell Mobilization
Page 1 of 2

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 is ONLY to be used for mobilization dosing of filgrastim-sndz (G-CSF)

LABS:
□ CBC with differential, Routine, ONCE, prior to initiation of therapy
□ CBC with differential, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
□ Labs already drawn. Date: __________

MEDICATIONS:

filgrastim-sndz (ZARXIO), subcutaneous, ONCE
□ 10 mcg/kg = ________ mcg
□ ______ mcg/kg = ________ mcg
□ ______ mcg

Pharmacist will round dose to nearest vial or syringe combination and modify during order verification

Interval: (must check one)
□ Once daily for 4 days prior to first apheresis appointment
□ Once daily for ___ days
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: ___________

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