ADULT AMBULATORY INFUSION ORDER
Filgrastim-sndz (ZARXIO)

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: ___________

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. Hold treatment for ANC greater than or equal to _____/mm3 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.
### 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.

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.ohsu knight.com/infusionorders](http://www.ohsu knight.com/infusionorders)