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

PO7071

ADULT AMBULATORY INFUSION ORDER

Filgrastim Injection

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 Injection (G-CSF) for Stem Cell Mobilization" order form
3. Do NOT administer filgrastim 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

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MEDICATIONS: ***(must check one)***

1. **Doses for patients > 40 kg:**
   - ☐ filgrastim-ayow (RELEUKO) injection 300 mcg/0.5 mL subcutaneous, ONCE
   - ☐ filgrastim-ayow (RELEUKO) injection 480 mcg/0.8 mL subcutaneous, ONCE
2. **Dose for patients ≤ 40 kg:**
   - ☐ filgrastim-ayow (RELEUKO) injection 5 mcg/kg/dose subcutaneous, ONCE
3. **Other dose:**
   - ☐ filgrastim-ayow (RELEUKO) 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 1000/mm3 for 1 consecutive day
   - ☐ Daily until ANC is greater than or equal to _____/mm3 for __ consecutive days (if needing more than 1 consecutive day)

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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:** _____

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Printed Name:_____ **Phone:** _____ **Fax**:_____

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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