



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

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Filgrastim Injection  
For Hepatitis C**

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*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 be used for patients receiving peginterferon alfa-2a (PEGASYS) or peginterferon alfa-2b (PEGINTRON).
3. 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  $\geq$  75 kg

#### LABS:

CBC with differential, Routine, ONCE, prior to therapy  
 CBC with differential, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*  
 Labs already drawn. Date: \_\_\_\_\_

#### MEDICATIONS:

**filgrastim-ayow (RELEUKO) injection, subcutaneous, ONCE**

300 mcg  
 480 mcg  
 Other: \_\_\_\_\_ (*Pharmacist will round dose to nearest vial or syringe combination and modify during order verification*)

**Interval: (must check one)**

Once  
 Once a week x \_\_\_\_\_ doses. Administer on \_\_\_\_\_ day of week as it relates to peginterferon  
 Twice a week x \_\_\_\_\_ doses  
 Three times per week x \_\_\_\_\_ doses

#### NURSING ORDERS:

1. TREATMENT PARAMETERS – Continue treatment until absolute neutrophil count (ANC) is greater than or equal to  $1000/\text{mm}^3$ . Contact prescriber for additional orders if needed.
2. Prior to drawing a new CBC with differential, verify whether or not patient has had labs drawn since the time of last medication administration
3. Please schedule G-CSF to be given 24 hours before or 24-48 hours after peginterferon therapy if possible.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declothing (alteplase), and/or dressing changes.



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ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

*Patient Identification*

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**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: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_



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**OHSU  
Health**

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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](http://www.ohsuknight.com/infusionorders)