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

PO9031

ADULT AMBULATORY INFUSION ORDER

Filgrastim-sndz (ZARXIO)

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: _____

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-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 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)

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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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756