Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Filgrastim Injection For Hepatitis C** Page 1 of 2	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 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 ≥ 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/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, declotting (alteplase), and/or dressing changes.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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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