LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **FAX:** (541) 271-5433

FILGRASTIM / PEGYLATED FIGRASTIM AND BIOSIMILARS

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments) _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- *Lab orders should **NOT** be included on this form – place orders via usual method. **Lab monitoring is the responsibility of the ordering Provider.***
- *This treatment plan will expire **after 365 days**, at which time new orders will need to be placed.*

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or** most recent chart note

PEGFILGRASTIM (LONG-ACTING) PREFERRED AGENTS:

☒ **Select Product:**

☐ PREFERRED Biosimilar: **pegfilgrastim-pbbk** *(FYLNETRA)* injection, 6 mg, subcutaneous

☐ ALTERNATIVE Biosimilar: **pegfilgrastim-jmdb** *(FULPHILA)* injection, 6 mg, subcutaneous

Other biosimilar: _____

***NOTE** reason for not selecting one of the preferred product **(required)**:* _____

☒ **Select Interval:**

☐ Once Other: _____

FILGRASTIM (SHORT-ACTING) PREFERRED AGENTS:

☒ **Select Product:**

☐ PREFERRED Biosimilar: **filgrastim-ayow** *(RELEUKO)* injection, subcutaneous

Other biosimilar: _____

***NOTE** reason for not selecting preferred product **(required)**:* _____

Continued on next page ➔

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient Label

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Patient Name _____ **DOB** _____

☒ **Select Dose:**
- ☐ 300 mcg (for patient weight of 70 Kg or less)
- ☐ 480 mcg (for patient weight over 70 Kg)

Other dose: _____

☒ **Select Interval:**
- ☐ Once
- ☐ Once a week for _____ doses
- Other: _____

LABS - NURSE DRAW *(ONLY for ordering labs to be done on the day of infusion)*:

☒ _____

☒ _____

☒ _____

NURSING ORDERS:

☒ If patient has received radiation or chemotherapy within 24 hours of administration, **contact provider for guidance.**

LINE CARE MAINTENANCE: LINE CARE MAINTENANCE:

☒ Follow facility policies/procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes

☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL intra-catheter **x** 1 PRN de-clotting **x** 2 doses

☒ **heparin, porcine - Preservative Free (PF)** 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care

☒ **0.9% sodium chloride** 10 mL IV flush PRN as needed

☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

☒ **STOP MEDICATION INFUSION if allergic reaction occurs**

☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction

☒ VS Q15 minutes **x** 4 and PRN

☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.

☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***

☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction

☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider

☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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