METRO INFUSION CENTER

Pegfilgrastim (and biosilimars)

Name: ____
DOB: ____
Diagnosis/Code: ____________________/__________

Dose calculation:
Flat dose, not a weight-based medication

Laboratory or Other Tests Related to Chemotherapy: **Provider to select preference below**

Dosing Guidelines/ Parameters:
Assure that patient received chemotherapy at least 24 hours prior (may be longer)

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: ☐ Not Required

Medication Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Neulasta® (pegfilgrastim)	6mg	SQ	One dose post each chemotherapy regimen
☐ Fulphila™ (pegfilgrastim-jmdb)	6mg	SQ	One dose post each chemotherapy regimen
☐ Nyvepria™ (pegfilgrastim-apgf)	6mg	SQ	One dose post each chemotherapy regimen
☐ Udenyca™ (pegfilgrastim-cbqv)	6 mg	SQ	One dose post each chemotherapy regimen
☐ Ziextenzo™ (pegfilgrastim-bmez)	6mg	SQ	One dose post each chemotherapy regimen
☐			

Chemotherapy was given on: ______________________________________

Chemotherapy given: ____

This order is good for 1 year from the date ordered

Other:

Call referring provider for:

Other reasons to call:

DATE	Referring Provider:______________________ (SIGNATURE REQUIRED) ________________________ (PRINTED NAME REQUIRED) Telephone#___________________________

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com