MIC METRO INFUSION CENTER

# Pegfilgrastim (and biosimilars)

Please check box ☐ if ok to substitute with a Pegfilgrastim biosimilar per insurance preferred product

Name: _____
DOB:_____
Diagnosis/Code: _____/_____
Cancer Stage:_____

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

**Dosing Guidelines/Parameters:** ***Provider must select hold parameters that will trigger a call from the Infusion Staff***

☐ Assure that patient received chemotherapy at least 24 hours prior (may be longer)

**Hydration Orders:** Not required

**Premedication and Antiemetic Orders:** Not required

**Treatment 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 |
| ☐ Fylnetra (pegfilgrastim-pbbk) | 6mg | SQ | One dose post each chemotherapy regimen |
| ☐ Udenyca™ (pegfilgrastim-cbqv) | 6 mg | SQ | One dose post each chemotherapy regimen |
| ☐ Stimufend (pegfilgrastim-fpgk) | 6mg | SQ | One dose post each chemotherapy regimen |
| ☐ Ziextenzo™ (pegfilgrastim-bmez) | 6mg | SQ | One dose post each chemotherapy regimen |
| ☐ Armlupeg (pegfilgrastim-unne) | 6mg | SQ | One dose post each chemotherapy regimen |

Chemotherapy given:_____

Chemotherapy was given on:_____
Injection must be given within _____days of chemotherapy each cycle.
***This order is good for 1 year from the date ordered***

Other:

Call referring provider for:

Date:

Referring Provider:_____ _____ Phone# _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

**Office Contact name/number:**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.comor fax to (866)507-1164

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