MIC | METRO INFUSION CENTER

Name:
DOB:
Diagnosis/Code: /

# Leuprolide Acetate (Eligard) SQ

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

**Laboratory or Other Tests Related to treatment:**

**Dosing Guidelines/ Parameters:**

**Hydration Orders:** ☐ Not Required

**Premedication and Antiemetic Orders:** ☐ Not Required

**Medication Orders:**

| DRUG | DOSE | ROUTE | DAYS TO BE GIVEN |
|---|---|---|---|
| | | | |
| ☐ Eligard® (leuprolide) | 7.5 mg | SQ | Every 28 days |
| ☐ Eligard® (leuprolide) | 11.25 mg | SQ | ☐ Every 28 days<br>☐ Every 3 months |
| ☐ Eligard® (leuprolide) | 15 mg | SQ | Every 28 days |
| ☐ Eligard® (leuprolide) | 30 mg | SQ | Every 16 weeks |
| ☐ Eligard® (leuprolide) | 22.5 mg | SQ | 3 months |
| ☐ Eligard® (leuprolide) | 45 mg | SQ | 6 months |
| ☐ Eligard® (leuprolide) | _____ | SQ | Every _____ weeks<br>☐ Every _____ months |

Date of intended first treatment at MIC: _____
Subsequent treatments may be given +/- 2 days or _____
This order is good for 1 year from the date ordered

**Other:**

Call referring provider for:

Other reasons to call:

**Date:** **Referring Provider:** _____ _____ **Telephone#** _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

All information contained in this order form is strictly confidential and will become part of the patient's medical record. Contact us with questions at: (877) 448-3627. Send competed form and all documentation to the Confidential email: Intake@Metroinfusioncenter.com or (866) 507-1164

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