METRO INFUSION CENTER

| Name: |
|---|
| DOB: |
| Diagnosis/Code: / |

## Lupron Depot®, Lupron Depot-PED (leuprolide)

**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 | INDICATION | DOSE | ROUTE | DAYS TO BE GIVEN |
|---|---|---|---|---|
| Leuprolide Depot | Endometriosis<br>Uterine fibroids | 3.75 mg | IM | Every 28 days |
| Leuprolide Depot<br>Lupron Depot PED | Advanced prostate cancer<br>Central Precocious puberty | 7.5 mg | IM | Every 28 days |
| Leuprolide Depot<br>Lupron Depot PED | Endometriosis<br>Uterine fibroids<br>Central Precocious puberty | 11.25 mg | IM | Every 28 days<br>Every 3 months |
| Leuprolide Depot<br>Lupron Depot PED | Central Precocious Puberty | 15 mg | IM | Every 28 days |
| Leuprolide Depot | Advanced Prostate Cancer | 22.5 mg | IM | Every 12 weeks |
| Leuprolide Depot | Advanced Prostate Cancer | 30 mg | IM | Every 16 weeks |
| Leuprolide Depot | Advanced Prostate Cancer | 45 mg | IM | Every 24 weeks |
| | | ____________ | IM | Every ____weeks<br>Every ____ weeks |

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 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: Intake@metroinfusioncenter.com or (866) 507-1164

Revised 3.20.23