MIC METRO INFUSION CENTER

Trastuzumab (Herceptin)

Name:_____
DOB: _____
Diagnosis/Code:_____/_____

Biosimilars that can be used:

☐ Herceptin (trastuzumab) ☐ Kanjinti™ (trastuzumab-anns) ☐ Ogivri (trastuzumab-dkst)
☐ Herzuma® (trastuzumab-pkrb) ☐ Trazimera (trastuzumab-qyyp) ☐ Ontruzant® (trastuzumab-dttb)

Weight:_____lb _____kg
☐ Call for weight change greater than 10 % from weight listed on order
☐ No dose modifications required for any weight change

BSA: N/A:
Mg/Kg dosing

Laboratory or Other Tests Related to Treatment

☐ CBC/differential prior to each dose
☐ CBC/Differential every_____cycles
☐ LVEF prior to starting treatment and then every 3/_____months; Last LVEF done:_____/Ejection fraction: _____

Dosing Guidelines/ Parameters:

☐ Hold and call for ANC less than_____ ☐ Platelets less than _____
☐ Other: _____
☐ No hold parameters

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: None (minimal emetogenic risk)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN, AND TOTAL DOSES
☐ Trastuzumab/Biosimilar	8 mg/kg	_____ mg	250 ml NS	IVPB	90 minutes	First dose only for Q3weekly dosing
☐ Trastuzumab/Biosimilar	6 mg/kg	_____ mg	250 ml NS	IVPB	☐30 minutes ☐90 minutes	Every 3 weeks
☐ Trastuzumab/Biosimilar	4mg/kg	_____mg	250ml NS	IVPB	90 minutes	First dose only for weekly load
☐ Trastuzumab/Biosimilar	2mg/kg	_____mg	250ml NS	IVPB	30 min	Weekly

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:
Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Signs and symptoms of CHF
2. New onset pulmonary symptoms

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.

Updated 3.20.23