MIC | METRO INFUSION CENTER

Daratumumab and Hyaluronidase fihj (DARZALEX Faspro®)

Name: _____
DOB: _____
Diagnosis/Code: _____/ _____
Cancer Stage/line of tx:_____/_____

Flat Dose | **BSA:** N/A

Patient clearance: ☐ **Submit patient consent**

Patient will be seen by oncology prior to every _____ cycle/week and cleared (MIC staff will assess prior to each dose)

Laboratory or other tests related to treatment that should be completed within _____ of treatment by referring prior to clearance for infusion:

Will be done at referring office (***Name and Phone# of who to expect labs from***):_____

☐ CBC with each treatment ☐ Other: _____

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

☐ Hold and call provider for ANC: _____ /Platelet: _____

☐ No hold for ANC/Plt

Hydration Orders:

Premedication ***Provider to select requirements below:***

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Diphenhydramine	25mg	☐ IV ☐ PO		1 hour to 3 hours before every DARZALEX infusion
☐ Acetaminophen	650mg	PO	_____	1 hour to 3 hours before every DARZALEX infusion
_____Steroid if not taken at home	_____mg			

Treatment orders:

DRUG	DOSE CALCULATION DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Daratumumab and hyaluronidase (Darzalex Faspro®)	1800 mg daratumumab plus 30.000units hyaluronidase	15ml	SQ	3-5 minutes	☐ Every 1 wk x _____ *Followed by* ☐ Every 2 Wks x _____ *Followed by* ☐ Every 4 Weeks starting _____
☐ Daratumumab and hyaluronidase (Darzalex Faspro®)	1800 mg daratumumab plus 30.000units hyaluronidase	15ml	SQ	3-5 minutes	

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other:

Oral cancer treatment patient is taking: _____

Call referring provider for:

Date:

Referring Provider: _____ _____ Phone# _____

SIGNATURE REQUIRED **PRINTED NAME REQUIRED**

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

Revised 2/10/25