MIC | METRO INFUSION CENTER

Leuprolide- IM injection

Lupron Depot, Lupron Depot Intramuscular-PED

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

Flat dose – not a weight-based medication

Laboratory or other tests related to treatment that should be completed prior to clearance for infusion:

Other:

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

No hold parameters

Hydration Orders:

Not required

Premedication and Antiemetic orders:

Not required (minimal emetogenic potential)

Treatment orders:

DRUG	INDICATION	DOSE	ROUTE	DATES TO BE GIVEN
☐ Leuprolide Depot	Endometriosis/Uterine fibroids	3.75 mg	IM	☐ Every 28 days
☐ Leuprolide Depot ☐ Lupron Depot PED	Advanced prostate cancer Central Precocious puberty	7.5 mg	IM	☐ Every 28 days
☐ Leuprolide Depot ☐ Lupron Depot PED	Endometriosis Uterine fibroids Central Precocious puberty	11.25 mg	IM	☐ Every 28 days ☐ Every 3 months
☐ Leuprolide Depot ☐ Lupron Depot PED	Central Precocious puberty	15 mg	IM	☐ Every 28 days
☐ Leuprolide Depot	Advance Prostate Cancer	22.5 mg	IM	☐ Every 12 weeks
☐ Leuprolide Depot	Advance Prostate Cancer	30 mg	IM	☐ Every 16 weeks
☐ Leuprolide Depot	Advance Prostate Cancer	45 mg	IM	☐ Every 24 weeks
			IM	Every _____ weeks Every _____months

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:

Call referring provider for:

Other reasons to call:

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

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