Trastuzumab (mark the approved product below)    Herceptin   Herzuma   Kanjinti   Ogivri		Name:					
Trastuzumab (mark the approved product below)    Herceptin   Herzuma   Kanjinti   Ogivri     Ontruzant   Trazimera	MIC METRO INFUSION CENTER			DOB:			
Herceptin   Herzuma   Kanjinti   Ogivri     Herzuma   Kanjinti   Ogivri     Herceptin   Herzuma   Kanjinti   Ogivri     Herzuma   He				Diagnosis/Code:/			
Herceptin   Herzuma   Kanjinti   Ogivri   Meight:	Trastuzumab (mark the approved product below)			Cancer stag	e:		
Ontruzant   Trazimera   Trazimera   Weight:   Ib		-					
Weight:		Ogivii					
Call for weight change greater than 10% from weight listed on order							
No dose modifications required for any weight change						<u> </u>	
Patient Clearance:							
Patient will be seen by Oncology Provider prior to every cycle(s) and cleared for treatment (Metro staff will also review symptoms prior to each treatment) Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/ days  Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:  Will be done at referring office (Name and phone# of who to expect labs from):  CMP with each treatment  CBC with each treatment  WEF assessment will be performed every 3 or months  Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff  Hold and call provider for ANC: /Platelet:  Other hold parameters LVEF that drops below the institutional normal or a >16% from baseline level OR has CHF/pulmonary symptoms between testing No hold parameters  Hydration Orders: Not required  Premedication and Antiemetic orders: Not required (low emetogenic potential)  Treatment orders:  DRUG DOSE CALCULATION DOSE ROUTE RATE FREQUENCY, DAYS TO BE GIVEN  Trastuzumab (biosimilar as above) 2 mg/kgmg   IVPB   Over 30 minutes   every3 weeks   every3 weeks   every3 weeks   every3 weeks   every3 weeks   every2 weeks   every3 weeks							
Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/							
Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:  Will be done at referring office (Name and phone# of who to expect labs from):  CMP with each treatment  CBC with each treatment  LIVEF assessment will be performed every 3 or	review symptoms prior to each treatment)						
Will be done at referring office (Name and phone# of who to expect labs from):  CMP with each treatment  CBC with each treatment  IVEF assessment will be performed every 3 or							
□ CMP with each treatment   □ LVEF assessment will be performed every 3 or			•	tu by referring	diffice prior to clea	manice for infusion.	
□ LVEF assessment will be performed every 3 ormonths         Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff         □ Hold and call provider for ANC:/Platelet:         □ Other hold parameters LVEF that drops below the institutional normal or a >16% from baseline level OR has CHF/pulmonary symptoms between testing No hold parameters         Hydration Orders: □ Not required         Premedication and Antiemetic orders: □ Not required (low emetogenic potential)         Treatment orders:         DRUG       DOSE CALCULATION       ROUTE       RATE       FREQUENCY, DAYS TO BE GIVEN         □ Trastuzumab (biosimilar as above)       2 mg/kg      mg       IVPB       Over 30 minutes       □ weekly         □ Trastuzumab (biosimilar as above)       4 mg/kg      mg       IVPB       □ over 30 min       □ weekly         □ Trastuzumab (biosimilar as above)       4 mg/kg      mg       IVPB       □ over 30 min       □ weekly	☐ CMP with each treatment	•	,				
Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff    Hold and call provider for ANC:	☐ CBC with each treatment						
Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff    Hold and call provider for ANC:	LVEF assessment will be performed every 3 or	months					
□ Other hold parameters LVEF that drops below the institutional normal or a >16% from baseline level OR has CHF/pulmonary symptoms between testing □ No hold parameters  Hydration Orders: □ Not required  Premedication and Antiemetic orders: □ Not required (low emetogenic potential)  Treatment orders:  DRUG DOSE CALCULATION DOSE ROUTE RATE FREQUENCY, DAYS TO BE GIVEN  □ Trastuzumab (biosimilar as above) 2 mg/kg			meters that w	ill trigger a co	all from the Infusion	n staff	
Hydration Orders: Not required  Premedication and Antiemetic orders: Not required (low emetogenic potential)  Treatment orders:  DRUG  DOSE CALCULATION  DOSE CALCULATION  DOSE CALCULATION  Premedication and Antiemetic orders: Not required (low emetogenic potential)  Treatment orders:  UPB  Over 30 minutes  every2 weeks every3 weeks over y3 weekly over y60 min over 90 min every2 weeks overy3 weeks	☐ Hold and call provider for ANC:	/Platelet:			_		
Hydration Orders: ☐ Not required         Premedication and Antiemetic orders: ☐ Not required (low emetogenic potential)         Treatment orders:       DRUG       DOSE CALCULATION       DOSE CALCULATION       ROUTE       RATE       FREQUENCY, DAYS TO BE GIVEN         ☐ Trastuzumab (biosimilar as above)       2 mg/kg      mg       IVPB       Over 30 minutes       ☐ weekly ☐ every2 weeks ☐ every3 weeks         ☐ Trastuzumab (biosimilar as above)       4 mg/kg      mg       IVPB       ☐ over 30 min ☐ weekly ☐ over 60 min ☐ every2 weeks ☐ over 90 min       ☐ every2 weeks ☐ over 90 min	Other hold parameters LVEF that drops below the institutional normal or a >16% from baseline level OR has CHF/pulmonary symptoms between testing						
Premedication and Antiemetic orders:  Not required (low emetogenic potential)  Treatment orders:  DRUG DOSE CALCULATION DOSE ROUTE RATE FREQUENCY, DAYS TO BE GIVEN  Trastuzumab (biosimilar as above) 2 mg/kg	☐ No hold parameters						
Treatment orders:  DRUG  DOSE CALCULATION  DOSE CALCULATION  DOSE CALCULATION  DOSE CALCULATION  DOSE CALCULATION  DOSE ROUTE RATE FREQUENCY, DAYS TO BE GIVEN  Weekly every2 weeks every3 weeks every3 weeks  very3 weeks over 30 min every3 weeks over 60 min over 90 min every3 weeks	Hydration Orders: ☐ Not required						
DRUG CALCULATION DOSE CALCULATION DOSE CALCULATION DOSE CALCULATION DOSE ROUTE RATE FREQUENCY, DAYS TO BE GIVEN  Over 30 minutes every2 weeks every3 weeks representation every3 weeks  Over 30 min every2 weeks every3 weeks over 90 min every3 weeks every3 weeks	Premedication and Antiemetic orders:   No	ot required (low er	netogenic potent	tial)			
CALCULATION  TO BE GIVEN	Treatment orders:						
☐ Trastuzumab (biosimilar as above)  2 mg/kg —_mg  IVPB Over 30 minutes ☐ every2 weeks ☐ every3 weeks ☐ every3 weeks ☐ over 30 min ☐ weekly ☐ Over 60 min ☐ every2 weeks ☐ over 90 min ☐ every3 weeks ☐ over 90 min ☐ every3 weeks	DRUG		DOSE	ROUTE	RATE		
☐ Trastuzumab (biosimilar as above)  4 mg/kg  ——mg  IVPB ☐ over 30 min ☐ weekly ☐ over 60 min ☐ every2 weeks ☐ over 90 min ☐ every3 weeks	☐ Trastuzumab (biosimilar as above)	2 mg/kg	mg	IVPB	Over 30 minutes	every2 weeks	
☐ Trastuzumab (biosimilar as above)  4 mg/kg ——mg IVPB ☐ Over 60 min ☐ every2 weeks ☐ over 90 min ☐ every3 weeks					Over 30 min	·	
□ over 90 min □ every3 weeks	☐ Trastuzumab (biosimilar as above)	4 mg/kg	mg	IVPB		l ′	
	, ,	0. 0				l	
I I I U over 30 min I ∐ weeklv					Over 30 min	weekly	
☐ Trastuzumab (biosimilar as above) 6 mg/kg ——— <sup>mg</sup> IVPB ☐ Over 60 min ☐ every2 weeks	☐ Trastuzumab (biosimilar as above)	6 mg/kg	mg	IVPB	<u> </u>	l '	
□ over 90 min □ every3 weeks		<i>5, 6</i>				·	
☐ Trastuzumab (biosimilar as above)  8 mg/kgmg IVPB Over 90 Minutes Initial loading dose	☐ Trastuzumab (biosimilar as above)	8 mg/kg	mg	IVPB			
Date of intended first treatment at Metro Infusion Center:	Date of intended first treatment at Metro Infusion Cer	ll nter:					
Subsequent treatment may be given +/- 2 days or as otherwise specified:			d:				
This order is good for 1 year from the date ordered		der is good for	r 1 year from t	the date orde	red		
Other:							
Oral cancer treatment patient is taking:							
Any SxS of CHF or pulmonary symptoms such as SOB; chest pain	Call referring provider for:  Any SxS of CHF or pulmonary symptoms such as 9	SOB: chest nain					
Date: Referring Provider: Phone#							
SIGNATURE REQUIRED PRINTED NAME REQUIRED	Date:   Referring Provider:						
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: <a href="mailto:lntake@metroinfusioncenter.com">lntake@metroinfusioncenter.com</a> or fax to (866)507-1164.	SIGNA						