MIC | METRO INFUSION CENTER

Name: _____
DOB:_____
Diagnosis/Code:_____/_____
Cancer stage:_____

Trastuzumab ***(mark the approved product below)***

☐ **Herceptin** ☐ **Herzuma** ☐ **Kanjinti** ☐ **Ogivri**
☐ **Ontruzant** ☐ **Trazimera**

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

Patient Clearance: **Attach treatment Consent Form** ☐

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

☐ **LVEF** 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/kg	_____mg	IVPB	Over 30 minutes	☐ weekly ☐ every2 weeks ☐ every3 weeks
☐ Trastuzumab (biosimilar as above)	4 mg/kg	_____mg	IVPB	☐ over 30 min ☐ Over 60 min ☐ over 90 min	☐ weekly ☐ every2 weeks ☐ every3 weeks
☐ Trastuzumab (biosimilar as above)	6 mg/kg	_____mg	IVPB	☐ over 30 min ☐ Over 60 min ☐ over 90 min	☐ weekly ☐ every2 weeks ☐ every3 weeks
☐ Trastuzumab (biosimilar as above)	8 mg/kg	_____mg	IVPB	Over 90 Minutes	Initial loading dose

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:

Any SxS of CHF or pulmonary symptoms such as SOB; chest pain

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.

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