MIC | METRO INFUSION CENTER

Elotuzumab **(EMPLICITI®)**

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

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:
Patient will be seen prior to every _____ cycle and cleared by Oncology Provider

Submit patient Consent Form ☐

Laboratory or other tests related to treatment that should be completed by *referring office* prior to clearance for infusion:
Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/_____days
☐ CMP with each treatment
☐ 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
☐ Hold and call for LFT's 5x ULN and/or Bilirubin 3x ULN; If different note acceptable parameters: _____
☐ No hold parameters

Hydration Orders:

Premedication Provider *to select requirements below:*

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Dexamethasone	8 mg	IVPB	20 minutes	45-90 minutes prior to treatment
☐ Famotidine	20mg	IVPB	20 minutes	45-90 minutes prior to treatment
☐ Diphenhydramine	25mg	☐ IV ☐ PO		45-90 minutes prior to treatment
☐ Acetaminophen	650mg	PO	_____	45-90 minutes prior to treatment

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Elotuzumab (EMPLICITI®)	10mg/kg	_____mg	As per Pharmacy	IVPB	**Cycle 1; DOSE 1** 0-30min: 0.5ml/min 30-60min: 1ml/min 60 min+: 2ml/min **Cycle 1 DOSE 2:** 0-30 min: 3ml/min 30+ min: 4ml/min **All subsequent doses:** 5ml/min	☐ Weekly x 8 from start of treatment ☐ Every week x ____ ☐ Every 2 weeks
☐ Elotuzumab (EMPLICITI®)	20mg/kg Cycles 3 and beyond	_____mg	As Per Pharmacy	IVPB	**Dose 1:** 0-30 min: 3ml/min 30 + min: 4ml/min **Dose 2 and beyond** 5ml/min	☐ Every 4 weeks ☐ Every ____Weeks

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.

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