MIC METRO INFUSION CENTER

Fulvestrant (Faslodex)

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

Dose calculation:
N/A

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

Hydration Orders:
N/A

Premedication and Antiemetic Orders:
N/A

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ **Fulvestrant (Faslodex)**	500mg*	IM in the dorsogluteal*	Loading every 2 weeks x 3 doses than monthly ☐ Day 1 ☐ Day 15 ☐ Day 29 ☐ Monthly starting after day 29 dose
☐ **Fulvestrant (Faslodex)**	500mg*	IM in the dorogluteal*	☐ Every 28 days (for pts who have already received the loading dosing)
☐ **Fulvestrant (Faslodex)**	250mg**	IM in the dorsogluteal	Loading every 2 weeks x 3 doses than monthly ☐ Day 1 ☐ Day 15 ☐ Day 29 ☐ Monthly starting after day 29 dose
☐ **Fulvestrant (Faslodex)**	250mg** (for elevated LFTs)	IM in the dorsogluteal	☐ Every 28 days (for pts who have already received the loading dosing)

*500mg dose is given in (2) 250mg/5ml injections in the dorsogluteal muscle on each buttocks. The injection should be given over 1-2minutes per injection.
**250mg dose I given as (1) 5ml injection in the outer gluteal muscle on each buttocks. The injection should be given over 1-2 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:

Call referring provider for:

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

Revised 1/13/25