



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Cemiplimab (Libtayo)

Weight: _____ lb _____ kg

 Call for weight change greater than 10% from weight listed on order No dose modifications required for any weight changeBSA: N/A
Mg/Kg dosing**Patient Clearance:**Attach treatment Consent Form

Patient will be seen by Oncology Provider prior to every _____ cycle 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 TSH Other: _____**Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff** Hold and call provider for ANC: _____ /Platelet: Hold and call for LFT's 3x or _____ ULN and/or Bilirubin 1.5x ULN Hold and call for creatinine 1.5x ULN No hold parametersHydration Orders: Not requiredPremedication and Antiemetic orders: Not required**Treatment orders:**

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
Cemiplimab (Libtayo)	Flat Dosing	350mg	As Per Pharmacy	IVPB	30 minutes	Every 3 weeks x _____ total doses
			As Per Pharmacy	IVPB		

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:** Administer using sterile, in-line or add-on 0.2-micron to 5-micron filter

Oral cancer treatment patient is taking: _____

Call referring provider for:

- | | |
|--|--|
| 1. Rash | Diarrhea of 6/day |
| 2. Elevated LFT's or creatinine as outline above | Severe SOB; pulse oximeter less than 90% |
| 3. Severe fatigue or weight loss | Neurologic changes |
| 4. 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.

Revised 1/13/25