MIC | METRO INFUSION CENTER

Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo)

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

N/A Flat dosing

BSA: N/A
Flat 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):

☐ CBC with each treatment
☐ CMP with each treatment
☐ **LVEF** assessment will be performed every 3 or _____months. Last LVEF done: _____/Ejection fraction: _____

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 _____
☐ 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
Initial Dose ☐ Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo)	Flat Dose	1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase/15 mL	SQ in the thigh	Over 8 minutes	X 1 only
Maintenance Dose ☐ Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo)	Flat Dose	600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase in 10 mL	SQ in the thigh	Over 5 minutes	Every 3 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:
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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