MIC | METRO INFUSION CENTER

Ramucirumab (Cyramza)

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

Weight:_____Lb/ _____kg

☐ Call for weight change greater than 10 % from weight listed on this order
☐ No dose modifications required for any weight change

BSA N/A:

Mg/Kg dosing

Laboratory or Other Tests related to treatment that should be completed prior to clearance for infusion:

Will be done with referring office (Name and phone# of who to expect labs from):_____

CBC/differential prior to each cycle ; ☐ CBC with Differential every _____cycle ☐ Not needed

☐ Urine protein every _____ cycles (call if a urine protein has not been done in 3 cycles)

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

☐ Hold and call provider for ANC less than 1000/1.0 and Platelets less than 75,000
☐ Hold and call provider for ANC less than_____; Platelet less than _____
☐ Urine protein +2
☐ No hold parameters

Hydration Orders: Not Required

Premedication and Antiemetic Orders: ☐ Antiemetic not required low emetogenic potential

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Diphenhydramine (Benadryl) (as per NCCN guidelines)	☐ 25 mg ☐ 50mg	☐ IVP	_____	30 minutes pre treatment

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN, AND TOTAL DOSES
☐ Ramucirumab	8mg/kg	_____mg	as per pharmacy	IVPB	60 min	Every 2 weeks (14 days)

Date of first intended treatment at Metro Infusion Center:_____

Subsequent treatments may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Oral cancer treatment patient is taking:_____

Call referring provider for:

1. Blood pressure that is trending up from baseline _____ (provider to insert blood pressure to be called for) MIC/MIDC staff to assure this is not one time reading.
2. Nose bleeds
3. + 2 protein on urinalysis
4. Persistent headaches unresolved by medication

Other reasons to call:

DATE	Referring Provider:_____ _____Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED

All information contained 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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