MIC METRO INFUSION CENTER

Somatuline® Depot (lanreotide)

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

Dose calculation:
Flat dose, not a weight based medication

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion Staff***
N/A- supportive medication. No clearance or consent required

Hydration Orders:
☐ Not required Other:

Premedication and Antiemetic Orders:
☐ Not required

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Somatuline® Depot (lanreotide) *Acromegaly*	60mg	Deep SQ *	☐ Every 4 weeks (for renal/hepatic dose reduction)
☐ Somatuline® Depot (lanreotide) *Acromegaly*	90mg	Deep SQ *	Every 4 weeks x _____doses Followed by _____
☐ Somatuline® Depot (lanreotide) *Neuroendocrine tumors/Carcinoid Acromegaly*	120mg	Deep SQ *	☐ Every 4 weeks ***Extended Maintenance dosing for acromegaly*** ☐ Every 6 weeks (extended maintenance dosing) ☐ Every 8 weeks (extended maintenance dosing)
☐ Somatuline® Depot (lanreotide)			

*superior external quadrant of the buttock

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:
-Worsening diarrhea
-Changes in heart rate/rhythm
-Abdominal pain
_____

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

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