



METRO INFUSION CENTER

Name: _____
 DOB: _____
 Diagnosis/Code: _____ / _____
 Cancer Stage/line of tx: _____

Daratumumab IV (DARZALEX®)

Weight: _____ lb / _____ kg

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

BSA: N/A
Mg/Kg dosing

Patient clearance:

Submit patient consent

Patient will be seen by oncology prior to every _____ cycle/week and cleared (MIC staff will assess prior to each dose)

Laboratory or other tests related to treatment that should be completed within _____ of treatment by referring prior to clearance for infusion:

Will be done at referring office (*Name and Phone# of who to expect labs from*): _____

- CBC with each treatment Other: _____

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

- Hold and call provider for ANC: _____ /Platelet: _____
 No hold parameters

Hydration Orders:

Premedication Provider to select requirements below:

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
<input type="checkbox"/> Dexamethasone	20 mg	IVPB	20 minutes	1 hour to 3 hours before every DARZALEX infusion
<input type="checkbox"/> Diphenhydramine	25mg	<input type="checkbox"/> IV <input type="checkbox"/> PO		1 hour to 3 hours before every DARZALEX infusion
<input type="checkbox"/> Acetaminophen	650mg	PO	_____	1 hour to 3 hours before every DARZALEX infusion

Treatment orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
<input type="checkbox"/> Daratumumab (Darzalex®)						First week must be given at the referring office/hospital due to duration of infusion and potential for allergic reaction
<input type="checkbox"/> Daratumumab (Darzalex®)	16mg/kg Weeks 2 and beyond	_____mg	As Per Pharmacy	IVPB	Week 2: Initial rate: 50ml x 1 hour Increase by 50ml/hr to a max of 200ml/hr Dose 3 and beyond Initial rate: 100ml x 1 hour Increase by 50ml/hr to a max of 200ml/hr for remaining volume	<input type="checkbox"/> Every 1 wk x _____ <i>Followed by</i> <input type="checkbox"/> Every 2 Wks x _____ <i>Followed by</i> <input type="checkbox"/> Every 4 Weeks starting _____

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:

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.

Revised 1/9/25