MIC | METRO INFUSION CENTER

Pertuzumab (Perjeta)

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

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):_____

☐ CMP with each treatment
☐ CBC with each treatment
☐ **LVEF** assessment will be performed every 3 or _____months

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 a >16% from baseline level OR has CHF/pulmonary symptoms between testing
☐ No hold parameters

Hydration Orders: ☐ Not required
Hydration orders needed:_____

Premedication and Antiemetic orders: ☐ Not required (minimal emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Pertuzumab (Perjeta)	Flat Dosing	840 mg	IVPB	Over 60 minutes	X 1 dose (first dose)
☐ Pertuzumab (Perjeta)	Flat Dosing	420mg	IVPB	☐ over 30 min ☐ Over 60 min	Every 3 weeks after loading dose

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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