MIC | METRO INFUSION CENTER

Tafasitamab-cxix (Monjuvi)

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

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: **Attach treatment Consent Form** ☐

Patient will be seen by Oncology Provider prior evvery_____ cycles; 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

☐ Other: _____

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:_____

☐ No hold parameters

Hydration Orders: ☐ Not required Or _____

Premedication and Antiemetic orders:

Mark premeds needed based on provider request and patient tolerance of treatment ☐ NOne needed as patient has tolerated first 3 infusions

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Acetaminophen	650mg	PO	_____	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
☐ Diphenhydramine	25mg	___PO ___IVP	Over 2 min	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
☐ Famotidine	20mg	IVP	Over 2 min	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
☐ Methylprednisolone				

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ **Tafasitamab-cxix (Monjuvi)**	12mg/kg	_____mg	IVPB	**First infusion:** start at 70 mL/h for the first 30 minutes, then, increase the rate so that the infusion is administered within 1.5 to 2.5 hours. **Subsequent cycles:** If no reaction with first infusion, may give over 1.5-2 hours	☐ Cycle 1: Days 1; 4; 8; 15; 22 ☐ Cycle 2 & 3: Day 1; 8; 15; 22 ☐ Cycle 4+: Days 1 and 15 Cycle=28 days total

What cycle is the patient starting at Metro infusion center:_____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.

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