MIC METRO INFUSION CENTER

Trelstar (triptorelin pamoate)

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***

Hydration Orders:

☐ Not required

☐ Other:

Premedication and Antiemetic Orders: ☐ Not required

Treatment Orders

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Trelstar (triptorelin pamoate)	3.75mg	IM	Every 4 weeks
☐ Trelstar (triptorelin pamoate)	11.25mg	IM	Every 12 weeks
☐ Trelstar (triptorelin pamoate)	22.5mg	IM	Every 24 weeks

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:

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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