



METRO INFUSION CENTER

Ado Trastuzumab Emtansine (Kadcyla)

****Can only be given in Illinois due to drug stability****

Name: _____

DOB: _____

Diagnosis/Code: _____/_____

Cancer Stage: _____

Weight: _____ lb

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 Treatment Consent Form

Patient will be seen by Oncology Provider prior to every _____ cycle 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): _____

CBC/differential prior to each dose

CMP with each cycle

LVEF prior to starting treatment and then every 3 or _____ months; Last LVEF done: _____/Ejection fraction: _____

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

Hold and call provider for ANC less than _____ and platelets less than _____

Hold and call provider for LFT's > _____ (3-5)xULN and/OR bilirubin greater than _____ (1.5x ULN)

Hold and call provider for drop in EF from baseline by more than 16% or less than _____

No hold parameters

Hydration orders:

Not required Hydration: _____

Premedication and Antiemetic Orders

None

DRUG	DOSE	ROUTE	RATE	FREQUENCY/DAYS TO BE GIVEN
Dexamethasone	8mg	PO	_____	Prior to each dose (low emetogenic potential as per NCCN)

Treatment Orders:

DRUG	DOSE CALCULAT ION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY/DAYS TO BE GIVEN/TOTAL DOSES
<input type="checkbox"/> Ado Trastuzumab (Kadcyla)	3.6 mg/kg	_____mg	As Per Pharmacy	IVPB	90 mins*	FIRST DOSE ONLY
<input type="checkbox"/> Ado Trastuzumab (Kadcyla)	3.6 mg/kg	_____mg	As per Pharmacy	IVPB	30 mins** all subsequent cycles	Every 3 weeks

*Monitor patient for 90 min post first dose for delayed reactions'

** Monitor patient for 30 minutes post all subsequent infusions

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatments may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Administer through a .22 micron in-line PES filter.

Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Signs and symptoms of CHF
2. New onset pulmonary symptoms
3. Signs of skin irritation if extravasated (drug is an irritant)
4. Significant peripheral neuropathy
5. Other reasons to call:

Date: _____ Referring Provider: _____ Phone# _____

SIGNATURE REQUIRED

PRINTED NAME REQUIRED

Office Contact: _____

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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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