MIC | METRO INFUSION CENTER

Daratumumab IV **(DARZALEX®)**

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

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
☐ Dexamethasone	20 mg	IVPB	20 minutes	1 hour to 3 hours before every DARZALEX infusion
☐ Diphenhydramine	25mg	☐ IV ☐ PO		1 hour to 3 hours before every DARZALEX infusion
☐ 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
☐ Daratumumab (Darzalex®)	First week must be given at the referring office/hospital due to duration of infusion and potential for allergic reaction					
☐ 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	☐ Every 1 wk x _____ *Followed by* ☐ Every 2 Wks x _____ *Followed by* ☐ 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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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