



METRO INFUSION CENTER

Daratumumab and Hyaluronidase fiHj (DARZALEX Faspro®)

Name: _____

DOB: _____

Diagnosis/Code: _____/_____

Cancer Stage/line of tx: _____/_____

Flat Dose

BSA: N/A

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 for ANC/Plt Hold for active infection

Hydration Orders:

Premedication Provider to select requirements below:

No premeds needed (patient has tolerated well without any premeds in the past)

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
<input type="checkbox"/> Diphenhydramine	25mg	<input type="checkbox"/> IV <input type="checkbox"/> PO		1 hour to 3 hours before every DARZALEX infusion
<input type="checkbox"/> Acetaminophen	650mg	PO	_____	1 hour to 3 hours before every DARZALEX infusion
_____ Steroid if not taken at home	_____mg			

Treatment orders:

DRUG	DOSE CALCULATION DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
<input type="checkbox"/> Daratumumab and hyaluronidase (Darzalex Faspro®)	1800 mg daratumumab plus 30.000units hyaluronidase	15ml	SQ	3-5 minutes	<input type="checkbox"/> Every 1 wk x _____ Followed by <input type="checkbox"/> Every 2 Wks x _____ Followed by <input type="checkbox"/> Every 4 Weeks starting _____
<input type="checkbox"/> Daratumumab and hyaluronidase (Darzalex Faspro®)	1800 mg daratumumab plus 30.000units hyaluronidase	15ml	SQ	3-5 minutes	

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.

Revised 12/2/25