MIC | METRO INFUSION CENTER

Leuprolide Acetate (Eligard) SQ

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

Flat dose – not a weight-based medication

Laboratory or other tests related to treatment that should be completed prior to clearance for infusion:
Other:

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion staff***
No hold parameters

Hydration Orders:

☐ Not required
☐ Other

Premedication and Antimetic orders:

☐ Not required (minimal emetogenic potential)

Treatment orders:

DRUG	DOSE	ROUTE	DATES TO BE GIVEN
☐ Eligard (Leuprolide)	7.5 mg	SQ	Every 28 days
☐ Eligard (Leuprolide)	11.25mg	SQ	☐ Every 28 days ☐ Every 3 months
☐ Eligard (Leuprolide)	15 mg	SQ	Every 28 days
☐ Eligard (Leuprolide)	30 mg	SQ	Every 16 weeks
☐ Eligard (Leuprolide)	22.5 mg	SQ	3 months
☐ Eligard (Leuprolide)	45 mg	SQ	6 months
☐ Eligard (Leuprolide)		SQ	☐ Every_____weeks ☐ Every_____months

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:
Other reasons to call:

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

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