MIC | METRO INFUSION CENTER

# Trastuzumab and hyaluronidase-oysk (HERCEPTIN HYLECTA®)

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

Flat dosing/no dose calculations

**BSA:** N/A
Mg/Kg dosing

**Patient Clearance:** **Attach 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
☐ CMP
☐ **LVEF** assessment will be performed every 3 or _____months. Last LVEF done: _____/Ejection fraction: _____
☐ Other: _____

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

☐ Hold and call provider for ANC: _____ /Platelet:_____
☐ Hold and call provider for drop in EF from baseline by more than 16% or less than _____
☐ No hold parameters

**Hydration Orders:**

☐ Not required ☐ Other_____

**Premedication and Antiemetic orders:**

☐ Not required (list emetogenic potential) OR _____

**Treatment orders:**

| DRUG | DOSE CALCULATION Flat dosing | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES |
|---|---|---|---|---|---|---|
| ☐ **Trastuzumab and hyaluronidase-oysk (Herceptin Hylecta)** | Flat Dose | 600mg trastuzumab/ 10,000 units Hyaluronidase | 5ml | SQ- R/L Thigh | Over 2-5 minutes | Every 3 weeks |
| ☐ **Trastuzumab and hyaluronidase-oysk (Herceptin Hylecta)** | Flat Dose | | | | | |

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:**

1. Any SxS of CHF or pulmonary symptoms such as SOB; chest pain

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