



METRO INFUSION CENTER

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

Atezolizumab and Hyaluronidase (Tecentriq Hybreza)

No dose calculations- dosed on Flat 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): _____

CMP with each treatment

CBC with each treatment

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 for LFT's 3x or _____ ULN and/or Bilirubin 1.5x ULN

Hold and call for creatinine 1.5x ULN

No hold parameters

Hydration Orders:

Not required

Premedication and Antiemetic orders:

Not required (very low emetogenic potential)

Treatment orders:

| DRUG | DOSE CALCULATION Flat dosing | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES |
|---|---------------------------------|--|---------------------|-------|-----------------------------|--|
| <input type="checkbox"/> TECENTRIQ HYBREZA (Atezolizumab and hyaluronidase-tqjs) | Flat Dosing | 1,875 mg atezolizumab and 30,000 units hyaluronidase | 15ml vial | SQ | Over 7 minutes in the thigh | Every 3 weeks |
| | | | | | | |

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. Rash | Diarrhea of 6/day |
| 2. Elevated LFT's or creatinine as outline above | Severe SOB; pulse oximeter less than 90% |
| 3. Severe fatigue or weight loss | Neurologic changes |
| 4. Skin reactions | Other reasons to call: _____ |

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