



# METRO INFUSION CENTER

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Diagnosis/Code: \_\_\_\_\_ / \_\_\_\_\_  
 Cancer Stage/line of tx: \_\_\_\_\_

## Elotuzumab (EMPLICITI®)

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:

Patient will be seen prior to every \_\_\_\_\_ cycle and cleared by Oncology Provider

Submit patient Consent Form

Laboratory or other tests related to treatment that should be completed by referring office prior to clearance for infusion: \_\_\_\_\_

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/ \_\_\_\_\_ days

- CMP with each treatment  
 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: \_\_\_\_\_  
 Hold and call for LFT's 5x ULN and/or Bilirubin 3x ULN; If different note acceptable parameters: \_\_\_\_\_  
 No hold parameters

### Hydration Orders:

#### Premedication Provider to select requirements below:

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
<input type="checkbox"/> Dexamethasone	8 mg	IVPB	20 minutes	45-90 minutes prior to treatment
<input type="checkbox"/> Famotidine	20mg	IVPB	20 minutes	45-90 minutes prior to treatment
<input type="checkbox"/> Diphenhydramine	25mg	<input type="checkbox"/> IV <input type="checkbox"/> PO		45-90 minutes prior to treatment
<input type="checkbox"/> Acetaminophen	650mg	PO	_____	45-90 minutes prior to treatment

### Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
<input type="checkbox"/> Elotuzumab (EMPLICITI®)	10mg/kg	_____mg	As per Pharmacy	IVPB	Cycle 1; DOSE 1 0-30min: 0.5ml/min 30-60min: 1ml/min 60 min+: 2ml/min Cycle 1 DOSE 2: 0-30 min: 3ml/min 30+ min: 4ml/min All subsequent doses: 5ml/min	<input type="checkbox"/> Weekly x 8 from start of treatment <input type="checkbox"/> Every week x _____ <input type="checkbox"/> Every 2 weeks
<input type="checkbox"/> Elotuzumab (EMPLICITI®)	20mg/kg Cycles 3 and beyond	_____mg	As Per Pharmacy	IVPB	Dose 1: 0-30 min: 3ml/min 30 + min: 4ml/min Dose 2 and beyond 5ml/min	<input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every _____ 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:

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