



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Fulvestrant (Faslodex)

Dose calculation:

N/A

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

Hydration Orders:

N/A

Premedication and Antiemetic Orders:

N/A

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
<input type="checkbox"/> Fulvestrant (Faslodex)	500mg*	IM in the dorsogluteal*	Loading every 2 weeks x 3 doses than monthly <input type="checkbox"/> Day 1 <input type="checkbox"/> Day 15 <input type="checkbox"/> Day 29 <input type="checkbox"/> Monthly starting after day 29 dose
<input type="checkbox"/> Fulvestrant (Faslodex)	500mg*	IM in the dorsogluteal*	<input type="checkbox"/> Every 28 days (for pts who have already received the loading dosing)
<input type="checkbox"/> Fulvestrant (Faslodex)	250mg**	IM in the dorsogluteal	Loading every 2 weeks x 3 doses than monthly <input type="checkbox"/> Day 1 <input type="checkbox"/> Day 15 <input type="checkbox"/> Day 29 <input type="checkbox"/> Monthly starting after day 29 dose
<input type="checkbox"/> Fulvestrant (Faslodex)	250mg** (for elevated LFTs)	IM in the dorsogluteal	<input type="checkbox"/> Every 28 days (for pts who have already received the loading dosing)

*500mg dose is given in (2) 250mg/5ml injections in the dorsogluteal muscle on each buttocks. The injection should be given over 1-2minutes per injection.

**250mg dose I given as (1) 5ml injection in the outer gluteal muscle on each buttocks. The injection should be given over 1-2 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: _____

Call referring provider for: _____

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

Revised 12/2/25