



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Trelstar (triptorelin pamoate)

Dose calculation:

Flat dose, not a weight based medication

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

Hydration Orders:

 Not required Other: _____**Premedication and Antiemetic Orders:** Not required

Treatment Orders

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
<input type="checkbox"/> Trelstar (triptorelin pamoate)	3.75mg	IM	Every 4 weeks
<input type="checkbox"/> Trelstar (triptorelin pamoate)	11.25mg	IM	Every 12 weeks
<input type="checkbox"/> Trelstar (triptorelin pamoate)	22.5mg	IM	Every 24 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: _____

Call referring provider for: _____

Oral chemotherapy patient is on: _____

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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