



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Leuprolide- IM injection

Lupron Depot, Lupron Depot Intramuscular-PED

Flat dose – not a weight-based medication**Laboratory or other tests related to treatment that should be completed prior to clearance for infusion:**

Other: _____

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

No hold parameters

Hydration Orders:

Not required

Premedication and Antiemetic orders:

Not required (minimal emetogenic potential)

Treatment orders:

DRUG	INDICATION	DOSE	ROUTE	DATES TO BE GIVEN
<input type="checkbox"/> Leuprolide Depot	Endometriosis/Uterine fibroids	3.75 mg	IM	Every 28 days
<input type="checkbox"/> Leuprolide Depot Lupron Depot PED	Advanced prostate cancer Central Precocious puberty	7.5 mg	IM	Every 28 days
<input type="checkbox"/> Leuprolide Depot Lupron Depot PED	Endometriosis Uterine fibroids Central Precocious puberty	11.25 mg	IM	<input type="checkbox"/> Every 28 days <input type="checkbox"/> Every 3 months
<input type="checkbox"/> Leuprolide Depot Lupron Depot PED	Central Precocious puberty	15 mg	IM	Every 28 days
<input type="checkbox"/> Leuprolide Depot	Advance Prostate Cancer	22.5 mg	IM	Every 12 weeks
<input type="checkbox"/> Leuprolide Depot	Advance Prostate Cancer	30 mg	IM	Every 16 weeks
<input type="checkbox"/> Leuprolide Depot	Advance Prostate Cancer	45 mg	IM	Every 24 weeks
			IM	<input type="checkbox"/> Every _____ weeks <input type="checkbox"/> Every _____ months

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:**

Other reasons to call: _____

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