



METRO INFUSION CENTER

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

Pertuzumab (Perjeta)

Flat Dosing

BSA: N/A
 Flat Dosing

Patient Clearance:

Attach treatment Consent Form

Patient will be seen by Oncology Provider prior to every _____ cycle(s) 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

LVEF assessment will be performed every 3 or _____ months Last LVEF done: _____ /Ejection fraction: _____

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

Hold and call provider for ANC: _____ /Platelet: _____

Other hold parameters LVEF that drops below the institutional normal or a >16% from baseline level OR has CHF/pulmonary symptoms between testing

No hold parameters

Hydration Orders: Not required

Hydration orders needed: _____

Premedication and Antiemetic orders: Not required (minimal emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
<input type="checkbox"/> Pertuzumab (Perjeta)	Flat Dosing	840 mg	IVPB	Over 60 minutes	X 1 dose (first dose)
<input type="checkbox"/> Pertuzumab (Perjeta)	Flat Dosing	420mg	IVPB	<input type="checkbox"/> over 30 min <input type="checkbox"/> Over 60 min	Every 3 weeks after loading dose

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:

Any SxS of CHF or pulmonary symptoms such as SOB; chest pain

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 or fax to (866)507-1164.

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