



METRO INFUSION CENTER

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

Tafasitamab-cxix (Monjuvi)

Weight: _____ lb _____ kg

BSA: N/A
Mg/Kg dosing

- Call for weight change greater than 10% from weight listed on order
 No dose modifications required for any weight change

Patient Clearance:

Attach treatment Consent Form

Patient will be seen by Oncology Provider prior every _____ cycles; 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
 Other: _____

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: _____
 No hold parameters

Hydration Orders: Not required Or _____

Premedication and Antiemetic orders:

Mark premeds needed based on provider request and patient tolerance of treatment None needed as patient has tolerated first 3 infusions

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
<input type="checkbox"/> Acetaminophen	650mg	PO	_____	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
<input type="checkbox"/> Diphenhydramine	25mg	____PO ____IVP	Over 2 min	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
<input type="checkbox"/> Famotidine	20mg	IVP	Over 2 min	30 minutes to 2 hours prior to tafasitamab-cxix (Monjuvi)
<input type="checkbox"/> Methylprednisolone				

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
<input type="checkbox"/> Tafasitamab-cxix (Monjuvi)	12mg/kg	_____mg	IVPB	First infusion: Start at 70 mL/h for the first 30 minutes, then, increase the rate so that the infusion is administered within 1.5 to 2.5 hours. Subsequent cycles: If no reaction with first infusion, may give over 1.5-2 hours	<input type="checkbox"/> Cycle 1: Days 1; 4; 8; 15; 22 <input type="checkbox"/> Cycle 2 & 3: Day 1; 8; 15; 22 <input type="checkbox"/> Cycle 4+: Days 1 and 15 Cycle=28 days total

What cycle is the patient starting at Metro infusion center: _____ 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 or fax to (866)507-1164.

Revised 12/7/25