



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____/_____

Cancer Stage: _____

Zynyz (retifanlimab-dlwr)

Flat Dosing**BSA: N/A**
Flat Dosing**Patient Clearance:****Attach treatment Consent Form**

Patient will be seen by Oncology Provider prior to every _____ cycle 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: _____ Hold and call for LFT's 3x or _____ ULN and/or Bilirubin 1.5x ULN Hold and call for creatinine 1.5x ULN No hold parameters**Hydration Orders:** Not required Other: _____**Treatment orders:**

DRUG	DOSING	DOSE	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
Zynyz (retifanlimab-dlwr)	Flat Dosing	500mg	IVPB	30 minutes	Every 4 weeks
Zynyz (retifanlimab-dlwr)					

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:**

Use polyethylene, polyurethane, or PVC with DEHP intravenous line containing a sterile, non-pyrogenic, low-protein binding polyethersulfone, polyvinylidene fluoride, or cellulose acetate 0.2 micron to 5 micron in-line or add-on filter or 15 micron mesh in-line or add-on filter.

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.

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