MIC | METRO INFUSION CENTER

**Ado Trastuzumab Emtansine (Kadcyla) This drug has limited distribution (only Chicago area)**

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

**Weight: _____lb_____kg**

☐ Call for weight change greater than 10% from weight listed on order

☐ No dose modifications required for any weight change

**BSA:** N/A
Mg/Kg 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

☐ LVEF prior to starting treatment and then 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:_____

☐ Hold and call provider for LFT's >5 x ULN or bilirubin 1.5 x ULN

☐ LVEF drop below _____ or ☐ 10% drop from previous

**Hydration Orders:** ☐ Not required ☐ Other_____

**Premedication and Antiemetic orders:**

☐ Not required (NCCN Low emetogenic potential)

| DRUG | DOSE | ROUTE | RATE | FREQUENCY, DAYS TO BE GIVEN |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Treatment orders:**

| DRUG | DOSE CALCULATION | DOSE | ROUTE | RATE | FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES |
|---|---|---|---|---|---|
| ☐ Ado Trastuzumab (Kadcyla) | 3.6mg/kg | _____mg | IVPB | ☐ 90 minutes (first dose only)** ☐ 30 minutes *** | Every 3 weeks |
| ☐ Ado Trastuzumab (Kadcyla) | | | | | |
| | | | | | |

**Observe patient for 90 minutes after 1st infusion;

***If tolerated first dose without any complications may run over 30 minutes AND observe for 30 minutes post infusion

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:**

Infuse with a 0.2 or 0.22 micron in-line polyether sulfone (PES) 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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