MIC | METRO INFUSION CENTER

Adcetris (Brentuximab Vedotin)
****Can only be given in Illinois due to drug stability****

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

Weight: _____kg (the dose is capped at a weight of 100kg- so if wt.>100kg will use 100kg to calculate the dose)

☐ 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 ☐ Other: _____-

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

☐ Hold and call provider for ANC less than: _____/Platelet:_____

☐ Call if bilirubin or LFT's _____

☐ No hold parameters

Hydration Orders: ☐ Not required ☐ Other_____

Premedication (only needed if prior reaction) and Antiemetic (low emetogenic potential) orders:

DRUG	DOSE	ROUTE	FREQUENCY, DAYS TO BE GIVEN
☐Acetaminophen	☐ 650 mg ☐ 1000 mg	PO	30 minutes prior to each dose (if had prior reaction)
☐ Diphenhydramine	☐ 25 mg ☐ 50 mg	☐ PO ☐ IVP	30 minutes prior to each dose (if had prior reaction)
☐ Dexamethasone	_____mg	PO	Prior to each dose (for low emetogenic potential OR prior allergic reaction)

Treatment orders:

DRUG	DOSE CALCULATION	DOSE	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Adcetris (Brentuximab Vedotin)	1.8mg/m2*	_____mg (dose is capped at 180mg)	IVPB	30 Minutes	Every 3 Weeks
☐ Adcetris (Brentuximab Vedotin)	1.2mg/m2*	_____mg (Dose is capped at 120mg)	IVPB	30 Minutes	☐Every 2 weeks ☐Every 3 weeks
☐ Adcetris (Brentuximab Vedotin)					

*Cap weight used at 100kg

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: Peripheral neuropathy

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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