MIC | METRO INFUSION CENTER

Unloxcyt (cosibelimab-ipdl)

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

Flat Dosing- no weight required

BSA: N/A
Mg/Kg 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)
Office Contact Name/Number/Fax:_____/_____/_____
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

☐ CMP with each treatment
☐ CBC with each treatment
☐ TSH ☐ 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

Premedication and Antiemetic orders: ☐ Not required

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ **UNLOXCYT (cosibelimab-ipdl)**	Flat Dosing	1200mg	As Per Pharmacy	IVPB	60 minutes	Every 3 weeks x_____ total doses
☐ **UNLOXCYT (cosibelimab-ipdl)**						

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: Administer using in-line or add-on of 0.2-micron to 0.22-micron filter

Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Rash
2. Elevated LFT's or creatinine as outline above
3. Severe fatigue or weight loss
4. Other reasons to call:

Diarrhea of 6/day
Severe SOB; pulse oximeter less than 90%
Neurologic changes

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.

Created 3/23/26