Local Infusion

MYLOCALINFUSION.COM

HERCEPTIN (TRASTUZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ HER2-overexpressing breast cancer, ICD 10: C16._____

❑ HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma, ICD 10: C50._____

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Herceptin	❑ 4mg/kg then 2mg/kg every _____ weeks for _____ weeks ❑ 8mg/kg then 6mg/kg every _____ weeks ❑ Other: _____	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499