

Ado-trastuzumab emtansine (Kadcyla)

Provider Order Form



Newport Superior Infusion

1501 Superior Ave, Suite 202

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Phone: 949-601-6001

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PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):		ICD-10 description:
☐ NKDA Allergies:	Weight lbs / kg:	Height in / cm:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):		

PROVIDER INFORMATION

Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- ☒ Provide nursing care per Newport Infusion Standard Procedures
- ☐ Hepatitis B status & date (list results here & attach clinicals):

- ☐ HER2 testing performed prior to administration

THERAPY ADMINISTRATION

- ☒ **Ado-transtuzumab emansine (Kadcyla)** intravenous infusion in 250mL of 0.9% NaCl
 - Dose ☐ 3.6 mg/kg / ☐ _____ mg/kg
Do not administer at doses greater than 3.6mg/kg
 - Frequency: ☐ Every 3 weeks (21-day cycle)
 - Rate
Administer first infusion over 90 minutes.
Administer all subsequent infusions over 30 minutes
if prior infusions were tolerated well
 - Route ☐ IV infusion
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

RECOMMENDED PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ famotidine (Pepcid) 20mg PO
- ☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ CRP ☐ at each dose ☐ every _____
- ☐ Other: _____

SPECIAL INSTRUCTIONS

Provider Name (Print)

Date

Provider Signature