

Trastuzumab (Herceptin)

Provider Order Form



Newport Superior Infusion

1501 Superior Ave, Suite 202

Newport Beach, CA 92663

Phone: 949-601-6001

Fax: 866-542-8631

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
- ☐ HER2 testing performed prior to administration

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

THERAPY ADMINISTRATION

- ☒ **Trastuzumab** (Herceptin) intravenous infusion in 250mL of 0.9% NaCl
- ☐ Dose
 - ☐ 8mg/kg over 90 minutes
 - ☐ 6mg/kg over 30-90 minutes
 - ☐ 4mg/kg over 30-90 minutes
 - ☐ 2mg/kg over 30 minutes
 - ☐ Frequency
 - ☐ Every 3 Weeks
 - ☐ Weekly
 - ☐ Once
 - ☐ Other: _____
- ☒ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print)

Date

Provider Signature