

Pertuzumab, Trastuzumab, and Hyaluronidase -zzxf (Phesgo)

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
- ☐ Hepatitis B status and date (list results and attach clinicals)

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

- ☒ **Pertuzumab, Trastuzumab, and Hyaluronidase - zzxf (Phesgo)** subcutaneous injection. For subcutaneous use in thigh only
- Dose
 - ☐ Initial: 1200mg-600mg-30,000 units administer subcutaneously over ~8 minutes
 - ☐ Maintenance: 600mg-600mg-20,000 units administer subcutaneously over ~5 minutes. Administer every 3 weeks
 - Site of Injection:
 - ☐ Left Thigh
 - ☐ Right Thigh
 - Refills: ☐ Zero / ☐ for 12 months
☐ _____ (if not indicated order will expire one year from date signed)

Provider Name (Print)

Date

Provider Signature