Herceptin (trastuzumab)

Provider Order Form rev. 5/20/2022

www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

C79.81 Cancer of the breast, metastatic

C16.9 Malignant neoplasm of stomach, unspecified

Other:______________________________

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose: _________ Route: _____ Frequency: ________________________.

MEDICATION ORDER

Herceptin (trastuzumab)

Dose:

4mg/kg for initial infusion followed by 2mg/kg IV

8mg/kg for initial infusion followed by 6mg/kg IV

Other: ____________________

Frequency:

weekly

every 3 weeks

Order Expiration Date (mm/dd/yy): ____________________
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order