

Herceptin (trastuzumab)

Provider Order Form rev. 5/20/2022

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
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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: _____

SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order

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)