Kadcyla (ado-trastuzumab emtansine)

Provider Order Form rev. 5/20/2022

www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

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

C50.______ Metastatic breast cancer

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

Kadcyla (ado-trastuzumab emtansine)

Dose:

3.6mg/kg IV

3mg/kg IV

2.4 mg/kg IV

Other: ___________________

Frequency:

Every 3 weeks

Other:______________

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