

**Patient Information**

|   |                     |                                    |                |
|---|---------------------|------------------------------------|----------------|
| Patient Name:   |                     | DOB:                               |                |
| Patient Home Phone:                                       | Patient Cell Phone: | Patient Email:                     |                |
| Emergency/Alternate Contact Name:                         |                     | Emergency/Alternate Contact Phone: |                |
| NKDA  | Allergies:          | Weight lbs/kg:                     | Height:        |
| Patient Status:   | New to Therapy      | Continuing Therapy                 | Therapy Change |
| Last infusion date (if applicable):                       |                     | _____                              |                |
| Is the patient pregnant, planning a pregnancy or nursing: |                     | Yes                                | No             |
| Does the patient need interpreter services:               |                     | Yes                                | No             |

**Provider Information**

|                            |  |                             |             |
|----------------------------|--|-----------------------------|-------------|
| Referral Coordinator Name: |  | Referral Coordinator Email: |             |
| Ordering Provider:         |  | Provider NPI:               |             |
| Referring Practice Name:   |  | Phone:                      | Fax:        |
| Practice Address:          |  | City:                       | State: Zip: |

**ICD-10 CODE**

C79.81 Cancer of the breast, metastatic      C16.9 Malignant neoplasm of stomach, unspecified      Other: \_\_\_\_\_

**Medication Order**

|   |              |   |                   |               |
|---|--------------|---|-------------------|---------------|
| <b>Herceptin</b> (trastuzumab)                    | <b>Dose:</b> | 4mg/kg for initial infusion followed by 2mg/kg IV | <b>Frequency:</b> | weekly        |
|   |              | 8mg/kg for initial infusion followed by 6mg/kg IV |                   | every 3 weeks |
|   |              | Other: _____                                      |                   |               |
| Access/De-access PICC/port per AleraCare protocol |              | Do NOT administer heparin to this patient         |                   |               |

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (need HER2 Status (positive) and Cardiac Assessment (LVEF))

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

**Pre-Medication Order**

|                                |         |       |              |   |          |                  |    |    |
|--------------------------------|---------|-------|--------------|---|----------|------------------|----|----|
| <b>acetaminophen</b> (Tylenol) | 500mg   | 650mg | 1000mg PO    | <b>diphenhydramine</b> (Benadryl)       | 25mg     | 50mg /           | PO | IV |
| <b>cetirizine</b> (Zyrtec)     | 10mg PO |       |              | <b>methylprednisolone</b> (Solu-Medrol) | 40mg IV  | 125mg IV         |    |    |
| <b>loratadine</b> (Claritin)   | 10mg PO |       |              | <b>hydrocortisone</b> (Solu-Cortef)     | 100mg IV |                  |    |    |
| Other: _____                   |         |       |              |   |          |                  |    |    |
| Dose: _____                    |         |       | Route: _____ |   |          | Frequency: _____ |    |    |

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

 \_\_\_\_\_  
**Provider Name**

 \_\_\_\_\_  
**Provider Signature**

 \_\_\_\_\_  
**Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

|                                   |                                    |      |   |   |          |   |   |
|-----------------------------------|------------------------------------|------|---|---|----------|---|---|
| Patient Name:                     | DOB:                               | Sex: | M | F | Fasting: | Y | N |
| Patient Home Phone:               | Patient Cell Phone:                |      |   |   |          |   |   |
| Emergency/Alternate Contact Name: | Emergency/Alternate Contact Phone: |      |   |   |          |   |   |

**Lab Test (Please circle or write in ICD-10)**

|                           |  |  |   |
|---------------------------|--|--|---|
| ALT                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgE                                      | J45.4, J45.3, L50.9, J45.40, J45.50   |
| AST                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgG                                      | G35, G36.0  |
| HEPATIC FUNCTION PANEL    | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IMMUNOGLOBULIN QUANT IgG, IgM, IgA       | G35, G36.0  |
| BASIC METABOLIC PANEL     | I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9                           | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE  | G35, G36.0  |
| CALCIUM                   | M81.0, M81.8   | IRON, TIBC, FER PNL                      | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| CBC (INCLUDES DIFF/PLT)   | I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1                          | LIPID PANEL                              | Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2                        |
| CBC (H/H, RBC, WBC, PLT)s | I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1                           | MAGNESIUM                                | I10, Z79.899, R25.2, E83.42, Z00.00   |
| COMP METABOLIC PANEL      | I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9                    | PSA                                      | R97.20, C61, N40.1, Z12.5, N40.0  |
| CREATININE                | M81.0, M81.8, G35  | PROTHROMBIN TIME-INR                     | Z79.01, I48.91, I48.0, Z51.81   |
| C-REACTIVE PROTEIN (CRP)  | R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50                       | TRANSFERRIN SATURATION                   | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| FERRITIN                  | D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9                                       | QUANTIFERON TB GOLD                      | Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| G6PD                      | M1A.9XX0, M1A.9XX1   | TSH                                      | E03.9, I10, E03.8, R53.83, E06.3, E05.00                                    |
| GROWTH HORMONE            | E22, C7A.1, E34  | URIC ACID                                | M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1                               |
| HEMOGLOBIN & HEMATOCRIT   | D50.9, D64.9, D50.0, D63.1, N18.9  | VIT B12/FOLIC ACID                       | M89.49, E53.8, R53.83, F41.8, F41.9, E05.00                                 |
| HEMOGLOBIN A1C            | E11.9, E11.65, R73.01, Z00.00, I10   | VIT D 25- HYDROX                         | E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8                           |
| HEP B SURF AG             | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs Not Listed (Write In) |   |

**Frequency**

Prior to each dose      Yearly      Other: Please Specify Below

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Provider Name \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Phone \_\_\_\_\_