

HERCEPTIN (TRASTUZUMAB)

Provider Order Form rev. 12/23/2021



PATIENT INFORMATION

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight lbs/kg: _____

Patient Status: New to Therapy Continuing Therapy 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: _____

ICD-10 Code

- C50._____ metastatic breast cancer/breast cancer adjuvant treatment
- C16._____ metastatic gastric cancer
- Other: _____

MEDICATION ORDER

Initial Dosing

- 4mg/kg IV every _____ weeks
- 8mg/kg every _____ weeks

Maintenance Dosing

- 2mg/kg every _____ weeks
- 6mg/kg every _____ weeks

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) _____ Provider Signature _____ Date _____

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months