

Pertuzumab (Perjeta)

Provider Order Form rev. 12/01/2021

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
- C50._____ Neoadjuvant Treatment of Breast Cancer
- Other: _____

MEDICATION ORDER

Perjeta

- Initial Dose: 840mg IV
- Maintenance: 420mg IV every 3 weeks

SPECIAL INSTRUCTIONS

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