# Trastuzumab Referral Form

**Preferred Clinic** (select one): _____

VIVO infusion®

**PATIENT INFORMATION**

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Dosing Weight (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Infusion Date: Last 4 Digits SSN:

**PROVIDER INFORMATION**

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

## STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.
☐ Infuse via Peripheral IV
☐ Infuse via Implanted Port
☐ Infuse via other vascular access device
_____

**Laboratory Orders to be completed by referring office prior to infusion**

**Name and phone # of who to expect labs from:** _____

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

☐ CBC w/ diff every _____

☐ CMP every _____

☐ OTHER _____

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

## PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

## TRASTUZUMAB ADMINISTRATION

☐ Infuse trastuzumab or trastuzumab biosimilar as required by patient's insurance.

☐ Do not use biosimilar (subject to prior authorization).

☐ 4 mg/kg week 1, then 2 mg/kg week 2-18 weekly, then 6 mg/kg every 3 weeks onward

☐ 4 mg/kg week 1, then 2 mg/kg weeks 2-12 weekly, then 6 mg/kg every 3 weeks onward

☐ 8 mg/kg week one, then 6 mg/kg week 4 every 3 weeks onward.

☐ Other:

☑ LVEF assessment: Every 3 months; send results to Vivo Infusion.

☐ Patient is on concurrent chemotherapy:

☐ Call for weight change greater than 10% from order form.

☐ No dose modifications required for weight change.

Calculated Dose (to be done by Vivo Infusion):

## REQUIRED DOCUMENTATION

☐ Patient Demographics

☐ Insurance Card/Information

☐ Progress Notes Supporting DX

☐ Current Medication List and H&P

☐ Complete Metabolic Panel, Complete Blood Count (within 3 months)

☐ HER2 pathology/testing

☐ Last LVEF completed: Ejection Fraction:

**Provider Name (Print)** **Provider Signature** **Date**

**Fax Referrals To: 855-314-0443** **Have a Question? Call (720) 902-4111**

**Referral is valid for one year unless otherwise noted.**

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