PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Trastuzumab (Herceptin ®)

Patient's Surname **Given Name & Initials**

Date of birth
_____ / _____ / _____
dd mm yyyy

Referring MD/Oncologist

Results of recent base line LV function study (please indicate):

Patient's
Height: _____ cm

Weight: _____ kg

BSA: _____ m^2

Dose Reduction? Yes ☐ No ☐

Reason_____

Cycle: _____

Pre-Medication

- Adetaminophen 650 mg po
- Benadryl 50 mg po/IV

- **Monitor Vitals prior and post dose.**
- Need 2D Echo or Syma pre initiation and repeat every 3 months.

Medication prescribed: **Please indicate (✓) which series of treatments this order refers to**

❒ Tx 1: Trastuzumab _____ mg (8.0 or _____ mg/kg)	❒ Tx 5-8: Trastuzumab _____mg (6.0 or _____mg/kg)	❒ Tx 13-16: Trastuzumab_____mg (6.0 or _____ mg/kg)
Tx 2-4: Trastuzumab _____ mg (6.0 or _____mg/kg)	❒ Tx 9-12: Trastuzumab_____mg (6.0 or _____ mg/kg)	❒ Tx 17: Trastuzumab _____ (6.0 or _____ mg/kg)

Tx ___ _____ Date	Tx ___ _____ Date
Tx ___ _____ Date	Tx ___ _____ Date

Scheduled Frequency

Repeat every 3 weeks

Physician's Signature (Referring Oncologist)	_____ / _____ / _____ dd mm yyyy
Signature of Provis Physician	_____ / _____ / _____ dd mm yyyy

Repeat Order:

Provis requires a new medication order for each series of 4 treatments.

Fax completed form to: **416-532-3635**

PROVIS

Information for Physicians
regarding
Herceptin® Infusion at Provis Infusion Clinic

Thank you for allowing Provis to assist in your patient's care.
We would like to make the coordination of systemic therapy at the Provis Clinic and your facility as easy and seamless as possible for both you and your patient.

1. Orders for Herceptin® in the adjuvant setting are written in blocks of 4 treatments given as a q 3 weekly infusions.

2. Please complete the **Medication Order Form** for Herceptin® and fax to 416-532-3635.

3. A **measure of left ventricular function** is required before the first treatment and every time the patient has completed 4 treatments. We will ask your patient to remind your office of this requirement when the 3rd treatment in the series has been completed.

4. Please forward the results of these studies to Provis at our confidential Fax No. **416-532-3635**

Thank you for your cooperation.

The Provis Team