METRO INFUSION CENTER

Daratumumab and Hyaluronidase-fihj (Darzalex/Faspro)

Name: ____
DOB: ____
Diagnosis/Code: _____________________/__________

Dose calculation:
Flat dosing

Laboratory or Other Tests Related to Chemotherapy:
☐ CBC
☐ ____

Dosing Guidelines/ Parameters: **Provider must select one option below**
☐ Hold and call provider for ANC less than or equal to 1500; Platelets less than or equal to 100,000
☐ Hold and call provider for ANC less than or equal to ________; Platelets less than or equal to__________
☐ ____

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: ☐ No antiemetic needed

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Acetaminophen (Tylenol)	☐ 650mg ☐ 1000mg	PO	_____	1-3 hours prior to each dose
☐ Diphenhydramine (Benadryl)	☐ 25 mg ☐ 50mg	☐ PO ☐ IVP	_____	1-3 hours prior to each dose
☐ ____________________ (steroid premed if needed if not taking oral dex already)	☐ ___________mg	☐ PO ☐ IVP		1-3 hours prior to each dose

Treatment Orders:

DRUG	DOSE CALCULATION DOSE	SOLUTION AND VOLUME	ROUTE	RATE	DAYS TO BE GIVEN
☐ Daratumumab and hyaluronidase	1800mg daratumumab and 30,000units hyaluronidase	15ml	SQ	3-5 minutes	Weekly x _____ Dates__________________
☐ Daratumumab and hyaluronidase	1800mg daratumumab and 30,000units hyaluronidase	15ml	SQ	3-5 minutes	Every 2 weeks x ______Doses Dates: _________________
☐ Daratumumab and hyaluronidase	1800mg daratumumab and 30,000units hyaluronidase	15ml	SQ	3-5 minutes	Every 3 weeks x _______ doses Dates: _________________
☐ Daratumumab and hyaluronidase	1800mg daratumumab and 30,000units hyaluronidase	15ml	SQ	3-5 minutes	Every 4 weeks

Date of first treatment: ______________________________/subsequent treatments may be given +/- 2 days for greater than weekly
This order is good for 1 year from the date ordered

Oral cancer treatment patient is taking: ___________________________________

Observe patient for _________________________________ post injection for ______________cycles/doses

Call referring physician for:
- ____

Other reasons to call:

DATE	**Referring provider:**______________________ (SIGNATURE REQUIRED) ________________________ (PRINTED NAME REQUIRED) **Telephone#**________________________

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com