MIC | METRO INFUSION CENTER

Faslodex® (fulvestrant)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Dose calculation:
Flat dose, not a weight-based medication

Laboratory or Other Tests Related to Chemotherapy:

Dosing Guidelines/ Parameters:

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: ☐ Not Required
☐ _____

Medication Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Faslodex® (Fulvestrant) (Breast cancer)	☐ 500mg *	IM	☐ Day 1 ☐ Day 15 and then every 28 days
☐ Faslodex® (Fulvestrant) (fallopian tube/ovarian/peritoneal cancer)	☐ 500mg *	IM	☐ Day 1
☐ Faslodex® (Fulvestrant) (fallopian tube/ovarian/peritoneal cancer)	☐ 250mg**		☐ Day 15 and all subsequent doses
☐			

*500mg dose is given in (2) 5ml injections in the dorsogluteal muscle on each buttock. The injection should be given over 1-2 minutes per injection.
**250mg dose IS given as (1) 5ml injection in the dorsogluteal muscle on a buttock. The injection should be given over 1-2 minutes

Day 1 = _____ subsequent doses can be given +/- 2 days

This order is good for 1 year from the date ordered.

Other:
This drug can cause hypersensitivity reaction. Monitor patient for sxs of hypersensitivity reaction.

Call referring provider for:

Other reasons to call:

DATE	Referring Provider:_____ _____ Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED

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