



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____/_____

Somatuline® Depot (lanreotide)

Dose calculation:

Flat dose, not a weight-based medication

Laboratory or Other Tests Related to Chemotherapy: Provider to select preference below

- CBC
 CMP
 Thyroid function testing prior to starting therapy

Dosing Guidelines/ Parameters:

- Call for excessive diarrhea

Hydration Orders: Not Required Give _____ NS over _____**Premedication and Antiemetic Orders:** Not Required**Medication Orders:**

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
<input type="checkbox"/> Somatuline® Depot (lanreotide)	120 mg	SQ *	Every 28 days
<input type="checkbox"/> Somatuline® Depot (lanreotide)	90mg	SQ*	Every 3 months
<input type="checkbox"/> Octreotide Acetate (Sandostatin LAR)	40mg	IM*	Every 28 days

*For deep subcutaneous injection only. Administer in the superior external quadrant of the buttock

Day 1 = _____ subsequent doses can be +/- 2 days of scheduled day.

This order is good for 1 year from the date ordered

Other:**Call referring provider 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