MIC | METRO INFUSION CENTER

Ado Traztuzumab Emtansine (Kadcyla)

Name: _____
DOB: _____
Diagnosis/Code: _____

Weight: _____kg

☐ Call for weight change greater than 10 % from baseline
☐ No dose modifications required for any weight change

BSA: N/A:

Mg/Kg dosing

Dosing Guidelines/ Parameters: **Provider must select hold parameters that will trigger a call from the RN**

☐ CBC/differential prior to each dose
☐ CBC/Differential every _____cycles
CMP with each cycle
☐ LVEF prior to starting treatment and then every 3 months; Last LVEF done: _____/Ejection fraction: _____

Dosing Guidelines/ Parameters:

☐ Hold and call provider for ANC less than 1000 and Platelets less than 75,000
☐ Hold and call provider for: _____
☐ Hold and call for LFT's >5 x ULN or bilirubin 1.5x ULN
☐ No hold parameters

Hydration Orders: Not Required

Premedication and Antiemetic Orders:

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Dexamethasone	8mg	PO	---	Prior to each dose (low emetogenic potential as per NCCN)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN, AND TOTAL DOSES
☐ Ado Trastuzumab (Kadcyla)	3.6 mg/kg	_____ mg	250 ml NS	IVPB	90 minutes*	First dose only
☐ Ado Trastuzumab (Kadcyla)	3.6 mg/kg	_____ mg	250 ml NS	IVPB	30 minutes all subsequent cycles	Every 3 weeks

* Monitor patient for 30-60 minutes post first dose for delayed reactions

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

Other:
Administer through a .22micron in line PES filter
Oral cancer treatment patient is taking: _____

Call referring provider for:

1. LVEF less than or equal to 40
2. Signs and symptoms of CHF
3. New onset pulmonary symptoms
4. Signs of skin irritation if extravasated (drug is an irritant)
5. Significant peripheral neuropathy

Other reasons to call:

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