MIC METRO INFUSION CENTER

# Pertuzumab (Perjeta)

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

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

**BSA:** N/A:

Flat Dosing

**Laboratory or Other Tests Related to Chemotherapy:**
☐ CBC/differential prior to each dose
☐ CBC/Differential every _____cycles
☐ LVEF prior to starting treatment and then every 3 months; Last LVEF done: _____/Ejection fraction: _____

**Dosing Guidelines/ Parameters:**
☐ ANC less than 1000 ☐ Platelets less than 75,000
☐ Other: _____
☐ No hold parameters

**Hydration Orders:** Not Required

**Premedication and Antiemetic Orders: None** ☐ Not Required (minimal emetogenic potential)

**Treatment Orders:**

| DRUG | DOSE CALCULATION | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DAYS TO BE GIVEN, AND TOTAL DOSES |
|---|---|---|---|---|---|---|
| ☐ Pertuzumab (Perjeta) | Flat Dosing | 840 mg | 250 ml NS | IVPB | 60 minutes | First dose only |
| ☐ Pertuzumab (Perjeta) | Flat Dosing | 420 mg | 250 ml NS | IVPB | 30 minutes | ☐ Every 2 weeks<br>☐ Every 3 weeks |
| | | | | | | |

Date of first treatment: _____/subsequent treatments may be given +/- 2 days

This order is good for 1 year from the date ordered

**Other:**
Monitor the patient for 30 minutes after infusion for delayed reaction

Oral cancer treatment the patient is also taking: _____

**Call referring provider for:**
1. Signs and symptoms of CHF
2. New onset pulmonary symptoms
3. Diarrhea of more than 2-3/day
4. LFT abnormalities

Other reasons to call:

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