P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

Enhertu™ (Trastuzumab deruxtecan)

Patient's Surname Given Name & Initials	**Date of birth** _______ / ______ / ___________ dd mm yyyy
Referring MD/Oncologist	

Results of recent base line LV function study (please indicate):

Patient's Height: ___________ cm Weight: ___________ kg BSA: ____________ m^2	Full Dose? Yes ☐ No☐ **5.4 mg/kg** Dose Reduction? Yes ☐ No☐ **4.4 mg/kg ☐ 3.2 mg/kg☐** Reason____ Cycle: ____

Pre-Medication: If Required:

- Acetaminophen 650 mg po
- Diphenhydramine 50 mg po/IV- Meperidine 50 mg IV prn
- Famotidine 20 mg IV
- Dexamethasone 10mg IV prn

- **Monitor Vitals prior and post dose.**
- Evaluate LVEF prior to initiation and every three months thereafter
- Need 2D Echo or MUGA pre initiation and repeat every 3 months.

Medication prescribed:

❒Tx 1 – 4: 5 onward Enhertu______ mg (5.4mg/kg or _____mg/kg) **in 100mL D5W IV over (90 minutes for initial ___Treatment and 30 minutes for subsequent Treatment(s) if first infusion is well tolerated)**

Tx ___ Date __________________________	Tx ___ Date __________________________
Tx ___ Date __________________________	Tx ___ Date __________________________

Scheduled Frequency

Repeat every 3 weeks

Physician's Signature (Referring Oncologist)	______ / ______ / ___________ dd mm yyyy
Signature of Provis Physician	______ / ______ / ___________ dd mm yyyy

Repeat Order:

Provis requires a new medication order for each series of 4 treatments.

Fax completed form to:416-532-3635

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Provis Patient No.

Information for Physicians
Regarding
Enhertu™ (Trastuzumab deruxtecan) Infusion at Provis Infusion Clinic

Thank you for allowing Provis to assist in your patient's care.

We would like to make the coordination of systemic therapy at the Provis Clinic and your facility as easy and seamless as possible for both you and your patient.

Our Clinic Administrator will be in contact with your office to confirm this date.

1. Orders for Enhertu™ (Trastuzumab deruxtecan) in the metastatic setting are written in blocks of 4 treatments given as a q 3 weekly infusions.

2. Please download and complete the **Medication Order Form** for Enhertu™ (Trastuzumab deruxtecan) available from our website and fax to 416-532-3635.

3. A **measure of left ventricular function** is required before the first treatment and every time the patient has completed 4 treatments. We will ask your patient to remind your office of this requirement when the 3rd treatment in the series has been completed. A positive HER-2 is required in advance of initiating therapy.

4. Please forward the results of these studies to Provis at our confidential Fax No. **416-532-3635**

If there are any questions or concerns, please do not hesitate to contact our office at Tel. 416-595-0500.

Provis Infusion Clinic Inc.