INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

# Phesgo *pertuzumab, trastuzumab, and hyaluronidase-zzxf*

## PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

## DIAGNOSIS

*Provider must specify*

In combination with chemotherapy as:

☐ Neoadjuvant treatment of patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer

☐ Adjuvant treatment of patients with HER2-positive early breast cancer at high risk of recurrence

In combination with:

☐ Docetaxel for treatment of patients with HER2-positive metastatic breast cancer (MBC) who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

Malignant neoplasm of the female breast, ICD 10: C50. _____

## PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

## PREREQUISITES TO TREATMENT

*Ensure the following is complete and attached with the referral*

☐ Documentation of which combined therapy patient is currently on
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

## PRE-MEDICATION

*Not typically indicated*

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

## MEDICATION ORDER

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Phesgo | Initial dose: 1,200 mg pertuzumab / 600 mg trastuzumab / 30,000 units hyaluronidase<br>Maintenance: 600 mg pertuzumab / 600 mg trastuzumab / 20,000 units hyaluronidase | Subcutaneous | Initial dose, then every 3 weeks |

## LABS / SPECIAL INSTRUCTIONS

*Order valid for 1 year from date of signature unless otherwise specified here:* _____