Trastuzumab/hyaluronidase (Herceptin HYLECTA)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

HER2 positive Breast Cancer: Metastatic Breast Cancer:

Other: Description:

THERAPY ADMINISTRATION

☑ Administer Herceptin Hylecta 600mg trastuzumab and 10,000 units hyaluronidase subcutaneously in the thigh over 2-5mins every 3 weeks for _____ doses

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ Echo or Muga scan must be obtained every 3 months while on therapy

☐ CBC w/diff, AST, ALT Every _____ weeks

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Symptoms of cardiomyopathy (arrhythmias, hypertension, recent MI and decreased LVEF)
- Symptoms of pulmonary toxicity (dyspnea, pulmonary edema, hypoxia, symptoms of lung disease)
- Positive pregnancy test
- History of allergic reaction to any component in Herceptin Hylecta.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Cardiac history. pulmonary history, pregnancy test, Echo or Muga scan with EF

Required Labs: Most recent CBC with diff, LFTs, HER2 test results.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.