



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: BRAVABR

**Class II Drug:**

**Indication for Use:**

- Progressive symptomatic breast cancer after adjuvant anthracycline-based chemotherapy.
- Second or third line treatment of metastatic breast cancer after previous combination chemotherapy with an anthracycline in a patient who has an ECOG status less than or equal to 2 and life expectancy greater than 3 months.
- Progressive breast cancer after failure of previous combination chemotherapy in a patient for whom anthracyclines are contraindicated and who has an ECOG status less than or equal to 2 and a life expectancy greater than 3 months.

For other indications, a BCCA "Compassionate Access Program" request must be approved prior to use

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
Date of Previous Cycle:					
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC <u>greater than or equal to 1.5 x 10<sup>9</sup>/L</u>, Platelets <u>greater than or equal to 100 x 10<sup>9</sup>/L</u></b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____					
<b>Proceed with treatment based on blood work from</b> _____					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.					
<input type="checkbox"/> <b>Other:</b>					
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>					
CHEMOTHERAPY:					
<b>paclitaxel-NAB 260 mg/m<sup>2</sup> x BSA = _____mg</b> <input type="checkbox"/> <b>Dose Modification:</b> _____mg/m <sup>2</sup> x BSA = _____mg IV over <b>30 minutes</b> (non-PVC equipment is NOT required, do NOT filter)					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ weeks.					
<b>CBC &amp; Diff, Platelets</b> prior to each cycle (Bilirubin, LFTs, Creatinine required prior to Cycle 1) If clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>Alk Phos</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>BUN</b>					
<input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: