



BC Cancer Agency

CARE & RESEARCH

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 and according to acceptable standards of care

PROTOCOL CODE: BRAVDOC7

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 of less than or equal to 2 and a 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 of less than or equal to 2 and a life expectancy greater than 3 months.
- Patient unable to tolerate BRAVDOC
- Patient unable to tolerate high dose dexamethasone used for BRAVDOC

*For other indications or for more than 4 cycles, an "Undesignated Indications Request" form must be approved prior to use.

DOCTOR'S ORDERS		Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form				
DATE:	To be given:	Cycle #:		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 24 hours ANC <u>greater than or equal to</u> 1.5 x 10⁹/L, Platelets <u>greater than</u> 90 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____				
Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____				
Dexamethasone 8 mg PO 1 hour prior to Docetaxel treatment.				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY:				
DOCetaxel (weekly) 36 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: : _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL (non-PVC bag) NS over 30 min to 1 hour. (Use non-PVC tubing)				
<input type="checkbox"/> Repeat dose as written x _____ weeks.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____. Book chemo weekly x 6 weeks. <input type="checkbox"/> Last Cycle. Return in _____ weeks.				
CBC & Diff, Platelets prior to each treatment. Prior to Cycle 3: Bilirubin, AST, ALT, GGT, Alk Phos If Clinically Indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos. <input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine				
<input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for further orders				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: