



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: BRAJTR

Class II Drug:

Indication for use:

Overexpression of HER-2 neu (+3 over-expression by IHC or +2 over-expression by IHC confirmed by FISH)

HER-2 neu positive breast cancer following completion of adjuvant chemotherapy in trastuzumab naïve patients

HER-2 neu positive breast cancer in patients on previous adjuvant chemotherapy containing trastuzumab

*For other indications, an "Undesignated Indication Form" must be approved prior to use.

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: _____ **To be given:** _____ **Cycle #:** _____

Date of Previous Cycle: _____

Have Hypersensitivity Reaction Tray and Protocol Available

TREATMENT:

Cycle 1 Only (Omit for patients completing BRAJACTT, BRJACTTG, BRLAACDT, UBRAJDCT):

Trastuzumab 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes.

Observe for 1 hour post infusion*.

OR

Cycle 2

Trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour every three weeks x _____ Cycle(s)

Observe for 30 minutes post infusion*.

Cycle 3 and Subsequent (Maximum 17 cycles total including previous adjuvant chemotherapy containing trastuzumab):

Trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 30 minutes** every three weeks x _____ Cycle(s)

Observe for 30 minutes post infusion*.

*Observation period not required after 3 treatments with no reaction

** 30 minute infusion time for Cycle 3 and all subsequent cycles, if no previous adverse reactions.

Acetaminophen 325 to 650 mg PO PRN for headache and rigors.

Proceed with treatment based on blood work from _____

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____.

Return in _____ weeks for Doctor and Cycle(s) _____.

Last Cycle. Return in _____ weeks.

MUGA Scan or Echocardiogram every 12 weeks from onset of trastuzumab and upon completion of treatment (17 cycles)

If clinically indicated x _____ weeks:

CBC & Diff, platelets prior to next treatment

ECG **Echocardiogram** **MUGA Scan**

CA15-3 **LFTs** **Creatinine**

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE: _____

SIGNATURE: _____

UC: _____