



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: BRAVTR

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**Class II Drug:**

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

- HER-2 neu Metastatic breast cancer progressing after 1 prior regimen
- HER-2 neu Metastatic breast cancer responding to 6 cycles of Trastuzumab in combination with Paclitaxel or Vinorelbine

\*For other indications, an "Undesignated Indication Form" 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:					
Have Hypersensitivity Reaction Tray and Protocol Available					
TREATMENT:					
<input type="checkbox"/> <b>Cycle 1 Only (omit for patients completing BRAVTRAP, BRAVTRAD, BRAVTRNAV, BRAVTPC):</b>					
Trastuzumab 8 mg / kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes.					
Observe for 1 hour post infusion*.					
<b>OR</b>					
<input type="checkbox"/> <b>Cycle 2 (Cycle 1 and subsequent for patients completing BRAVTRAP, BRAVTRAD, BRAVTRNAV, BRAVTPC)</b>					
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*.					
<input type="checkbox"/> <b>Cycle 3 and Subsequent: (Cycle 1 and subsequent for patients completing BRAVTRAP, BRAVTRAD, BRAVTRNAV, BRAVTPC)</b>					
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.					
<b>Acetaminophen 325 to 650 mg PO PRN for headache and rigors.</b>					
<b>Proceed with treatment based on blood work from _____</b>					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:



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<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. <input type="checkbox"/> Return in _____ weeks for Doctor and Cycle(s) _____.				
<b>CBC &amp; Diff, platelets prior to Cycle #2</b> <input type="checkbox"/> <b>CBC &amp; Diff, platelets every 12 weeks</b> If clinically indicated x _____ weeks:				
<input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>Echocardiogram</b> <input type="checkbox"/> <b>MUGA Scan</b> <input type="checkbox"/> <b>CA15-3</b> <input type="checkbox"/> <b>Tot. Prot</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>Alk Phos.</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>BUN</b> <input type="checkbox"/> <b>Creatinine</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:		