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: UBRAVTCAP

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment.

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:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 50 mL/min.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY:

Trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes on Day 1.

Capecitabine 1250 mg/m^2 or **1000 mg/m^2** (circle one) x BSA x (_____%) = _____mg PO BID with food x 14 days on days 1 –14. (Round dose to nearest 150 mg)

Acetaminophen 325 mg – 650 mg PO PRN for headache and rigors

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets, Creatinine prior to each cycle

☐ **INR Weekly** ☐ **INR prior to each cycle**

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.** ☐ **AST** ☐ **LDH** ☐ **ALT** ☐ **BUN** ☐

☐ **Other tests:** ☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: