



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: BRAJFECDT

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Class II Drug

Node positive early stage breast cancer (any T, N1-3) showing overexpression of HER-2

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: _____

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 90 x 10^9/L
Dose modification for: Hematology Other Toxicity
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm
Ondansetron 8 mg PO prior to FEC treatment
Dexamethasone 8 mg or 12 mg (circle one) PO prior to FEC treatment
Hydrocortisone 100 mg IV PRN
For DOCEtaxel Cycles: Dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel. Patient must receive 3 doses prior to treatment.
Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.
Other:

Have Hypersensitivity Reaction Tray and Protocol Available

CHEMOTHERAPY: (Note - continued over 2 pages)

CYCLE 1-3
Epirubicin 100 mg/m² x BSA = _____ mg
Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV push
Fluorouracil 500 mg/m² x BSA = _____ mg
Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV push
Cyclophosphamide 500 mg/m² x BSA = _____ mg
Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour
OR
CYCLE # 4 (Cycle 1 of Trastuzumab/DOCEtaxel)
Trastuzumab 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion.
DOCEtaxel 100 mg/m² x BSA = _____ mg
Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV in 250 to 500 mL NS (non-PVC bag) over 1 hour. (Use non-PVC tubing)

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 6 ***

DOCTOR'S SIGNATURE:

UC SIGNATURE:



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PROTOCOL CODE: UBRAJFECDT

DOCTOR'S ORDERS (Page 2 of 2)	
DATE:	To be given:
Cycle #:	
<p>CHEMOTHERAPY: (Continued)</p> <p style="text-align: center;">*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 4 ***</p> <p><input type="checkbox"/> CYCLE # 5</p> <p>Trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour. Observe for 30 minutes post infusion.</p> <p>DOCEtaxel 100 mg/m² x BSA = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg IV in 250 to 500 mL NS (non-PVC bag) over 1 hour (Use non-PVC tubing)</p> <p><input type="checkbox"/> Cycle # 6:</p> <p>Trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over NS over 30 minutes. Observe for 30 minutes post infusion.</p> <p>DOCEtaxel 100 mg/m² x BSA = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg IV in 250 to 500 mL NS (non-PVC bag) over 1 hour (Use non-PVC tubing)</p> <p>Acetaminophen 325 mg to 650 mg PO PRN for headache and rigors.</p>	
RETURN APPOINTMENT ORDERS	
<p><input type="checkbox"/> Return in three weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Last Cycle. Return in three weeks for BRAJTR (to continue single agent trastuzumab)</p>	
<p>CBC & Diff, Platelets prior to each cycle</p> <p>Prior to Cycle 4: Bilirubin, AST, ALT, Alk Phos</p> <p>If clinically indicated:</p> <p><input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos</p> <p><input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> Creatinine</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> MUGA scan or Echo: prior to Cycle 1 and 4 and every 12 weeks to completion of treatment</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: