**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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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
  - For Cycle 1-4, May proceed with doses as written if within 24 hours ANC greater than or equal to 1 x 10⁹/L,
  - Platelets greater than or equal to 100 x 10⁹/L
  - For Cycle 5-8, May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than 90 x 10⁹/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 ____________________________.

Select ONE of the following routine antiemetics regimens:

- □ ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
- □ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment
- □ netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment
- □ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment

As needed antiemetics:

- □ prochlorperazine 10 mg PO prn
- □ metoclopramide 10 mg PO prn

OR

45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in NS 50 mL over 15 minutes

30 Minutes Prior to PACLitaxel: diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)

- □ Other: ____________________________

**Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8**

**CHEMOTHERAPY: (Note – continued over 2 pages)**

- □ CYCLE #________ (Cycle 1-4)

  DOXOribucin 60 mg/m² x BSA = ___________ mg
  - Dose Modification: ______% = ___________ mg/m² x BSA = ___________ mg
  - IV push

  cyclophosphamide 600 mg/m² x BSA = ___________ mg
  - Dose Modification: ______% = ___________ mg/m² x BSA = ___________ mg
  - IV in NS 100 to 250 mL over 20 minutes to 1 hour

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8 ***

DOCTOR'S SIGNATURE: ____________________________

UB SIGNATURE: ____________________________
**DOCTOR’S ORDERS**

**DATE:**

**OR** □ CYCLE #5 DAY 1 (Cycle 1 of trastuzumab and PACLitaxel)

trastuzumab 8 mg/kg x _______ kg = _________ mg IV in NS 250 mL over 1 hour 30 minutes; observe for 1 hour post infusion

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
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<th>Pharmacist Initial and Date</th>
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<tr>
<td>trastuzumab</td>
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**CYCLE #5 DAY 2**

PACLitaxel 175 mg/m² x BSA = _________ mg

Dose Modification: _________ mg/m² x BSA = _________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

**OR** □ CYCLE #6 DAY 1

trastuzumab 6 mg/kg x _______ kg = _________ mg IV in NS 250 mL over 1 hour; observe for 30 minutes post infusion

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

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**PACLitaxel 175 mg/m² x BSA = _________ mg**

Dose Modification: _________ mg/m² x BSA = _________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

**OR** □ CYCLE # (Cycle 7, 8) DAY 1

trastuzumab 6 mg/kg x _______ kg = _________ mg IV in 250 mL NS over 30 minutes; observe for 30 minutes post infusion (not required after 3 treatments with no reaction)

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

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**PACLitaxel 175 mg/m² x BSA = _________ mg**

Dose Modification: _________ mg/m² x BSA = _________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

acetaminophen 325 to 650 mg PO PRN for headache and rigors

**DOCTOR’S SIGNATURE:**

UC SIGNATURE:

BC Cancer Provincial Preprinted Order BRAJACTTG
Created: July 14th, 2005 Revised: 1 Mar 2020
**PROTOCOL CODE: BRAJACTTG**

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<tr>
<th>RETURN APPOINTMENT ORDERS</th>
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<tr>
<td>☐ Return in <strong>two</strong> weeks for Doctor if cycles 1,2, 3, or 4</td>
</tr>
<tr>
<td>☐ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day__________</td>
</tr>
<tr>
<td>Return in ☐ <strong>two</strong> weeks or ☐ <strong>three</strong> weeks for Doctor and Cycle 5 Day 1 and 2 (physician discretion)</td>
</tr>
<tr>
<td>☐ Return in <strong>three</strong> weeks for Doctor and cycle 6,7, or 8</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in <strong>three</strong> weeks for Doctor and BRAJTR (to continue single agent trastuzumab)</td>
</tr>
</tbody>
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**CBC & Diff, Platelets** prior to each cycle

**Muga Scan or Echo** prior to Cycle 5 and then every ☐ 3 months or ☐ 4 months until completion of treatment

Prior to **Cycle 5**: ALT, Bilirubin

If clinically indicated: ☐ Creatinine ☐ Muga Scan ☐ Echocardiogram

☐ ALT ☐ Bilirubin

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

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