**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 or equal to** 1.5 x 10⁹/L, Platelets **greater or equal to** 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 __________________________.

dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment

and select ONE of the following:

- ☐ ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
- ☐ aprepitant 125 mg PO 30 to 60 minutes prior to AC treatment **on Day 1,** then **80 mg** PO daily on Day 2 and 3
- ☐ ondansetron 8 mg 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

As needed antiemetics:

- ☐ prochlorperazine 10 mg PO prn
- ☐ metoclopramide 10 mg PO prn
- ☐ Other

**OR**

- 45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL NS over 15 minutes
- 30 Minutes Prior to PACLitaxel: diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in 50 mL NS 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)

DOXOrubicin 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 100 to 250 mL NS over 20 minutes to 1 hour

*** SEE PAGES 2 and 3 FOR CHEMOTHERAPY CYCLES 5 TO 8 ***

**DOCTOR SIGNATURE:**

**BC Cancer Provincial Preprinted Order BRAJACTT**

Created: July 14, 2005  Revised: 1 Jun 2020
**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
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CHEMOTHERAPY: (Continued)

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

**DAY 1**

| trastuzumab 8 mg/kg | _______ 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>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>trastuzumab</td>
<td></td>
<td></td>
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</table>

**DAY 2**

<table>
<thead>
<tr>
<th>PACLitaxel 175 mg/m²</th>
<th>BSA</th>
<th>______ mg</th>
</tr>
</thead>
</table>

**OR**  
**CYCLE # 6** **DAY 1**

| trastuzumab 6 mg/kg | _______ 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

<table>
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<tr>
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BC Cancer Provincial Preprinted Order **BRAJACTT**

Created: July 14, 2005  Revised: 1 Jun 2020
**DOCTOR’S ORDERS (Page 3 of 3)**

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**OR**  
☐ CYCLE # (Cycle 7, 8) DAY 1

trastuzumab 6 mg/kg x ______ kg = ________ mg IV in NS 250 mL 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

**RETURN APPOINTMENT ORDERS**

☐ Return in three weeks for Doctor and Cycle______________ (Book Cycle #5 as Day 1 and 2)

☐ Last Cycle. Return in three weeks for BRAJTR (to continue single agent trastuzumab)

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.

**DOCTOR'S SIGNATURE:**

UC SIGNATURE: