PROTOCOL CODE: BRAJDCARBT

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 100 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 CARBOplatin treatment
For DOCEtaxel: dexemathasone 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 only**

trastuzumab 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion.

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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCEtaxel 75 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).
CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg
☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

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

DOCTOR'S SIGNATURE:	**UC SIGNATURE:**

DATE:

CHEMOTHERAPY: (Continued)

***** SEE PAGE 1 FOR CHEMOTHERAPY CYCLE 1 *****

☐ **CYCLE 2 only**

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in NS 250 mL over 1 hour. 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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCEtaxel 75 mg/m² x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).

CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

☐ **CYCLE 3 to 6**

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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCEtaxel 75 mg/m² x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).

CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

acetaminophen 325 mg to **650 mg** PO PRN for headache and rigors.

DOCTOR'S SIGNATURE:	**UC SIGNATURE:**

RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____ (maximum 6). ☐ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day_____ ☐ Last Cycle. Return in **three** weeks for Doctor and BRAJTR (for single agent trastuzumab).	
CBC and Diff, Platelets, Creatinine prior to each cycle. ☐ **MUGA scan or** ☐ **echocardiogram** (select one) prior to Cycle 1 and Cycle 5 and then every ☐ 3 months or ☐ 4 months until completion of treatment **If clinically indicated on subsequent cycles:** ☐ **Bilirubin** ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **LDH** ☐ **ALT** ☐ **Alk Phos** If clinically indicated: ☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **Other tests:** ☐ **Consults:** ☐ **See general order sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**UC SIGNATURE:**