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PROTOCOL CODE: BRAJDCARBT

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<table>
<thead>
<tr>
<th>DOCTOR'S ORDERS</th>
<th>Ht________cm</th>
<th>Wt________kg</th>
<th>BSA________m²</th>
</tr>
</thead>
</table>

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 10⁹/L, Platelets greater than or equal to 100 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 ___________________________
ondanetron 8 mg PO prior to CARBOplatin treatment

For DOCEtaxel: 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 only

trastuzumab (HERCEPTIN) 8 mg/kg x _______ kg = __________ mg IV in 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion.

DOCTAXEL 75 mg/m² x BSA = _______mg

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

IV in 250 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 250 mL NS over 30 minutes.

☐ CYCLE 2 only

trastuzumab (HERCEPTIN) 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)

DOCTAXEL 75 mg/m² x BSA = _______mg

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

IV in 250 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 250 mL NS over 30 minutes.

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 3 TO 6 ***

DOCTOR'S SIGNATURE: ___________________________ SIGNATURE: ___________________________

UC: ___________________________
**DATE:**

**CHEMOTHERAPY: (Continued)**

*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 AND 2 ***

- **CYCLE 3 to 6**

  - **Trastuzumab (Herceptin)** 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)

  - **Docetaxel** 75 mg/m² x BSA = _______mg
    - Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg
    - IV in 250 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 250 mL NS over 30 minutes.

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

**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** 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:**

**SIGNATURE:**

**UC:**

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(Please see page 2 of 2)

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