Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

**PROTOCOL CODE: BRAJFECDT**

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

**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** $1.5 \times 10^9/L$, **Platelets greater than or equal to** $90 \times 10^9/L$

Dose modification for:  
- [ ] Hematology
- [ ] Other Toxicity __________________________

Proceed with treatment based on blood work from

### PREMEDICATIONS:

Patient to take own supply. RN/Pharmacist to confirm __________________________.

- dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to FEC treatment
- select ONE of the following:
  - ondansetron 8 mg PO 30 to 60 minutes prior to FEC treatment
  - aprepitant 125 mg PO 30 to 60 minutes prior to FEC treatment on Day 1, then **80 mg** PO daily on Days 2 to 3
  - ondansetron 8 mg PO 30 to 60 minutes prior to FEC treatment
  - netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to FEC treatment

As needed antiemetics:

- prochlorperazine 10 mg PO prn
- metoclopramide 10 mg PO prn
- 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 $100 \text{mg/m}^2 \times \text{BSA} = ________\text{mg}$

- Dose Modification: ________% = ________ \text{mg/m}^2 \times \text{BSA} = ________\text{mg}

  - IV push

fluorouracil $500 \text{mg/m}^2 \times \text{BSA} = ________\text{mg}$

- Dose Modification: ________% = ________ \text{mg/m}^2 \times \text{BSA} = ________\text{mg}

  - IV push

cyclophosphamide $500 \text{mg/m}^2 \times \text{BSA} = ________\text{mg}$

- Dose Modification: ________% = ________ \text{mg/m}^2 \times \text{BSA} = ________\text{mg}

  - IV in 100 to 250 mL NS over 20 minutes to 1 hour

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 4 TO 6 ***

### DOCTOR’S SIGNATURE:

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

**DATE:** To be given: Cycle #: 

**CHEMOTHERAPY: (Continued)**

*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 3 ***

OR

☐ CYCLE # 4 (Cycle 1 of trastuzumab and DOCEtaxel)

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

<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>
</tr>
</tbody>
</table>

DOCEtaxel 100 mg/m² x BSA = _______mg

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

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

☐ CYCLE # 5

trastuzumab 6 mg/kg x _____ kg = ________mg IV in 250 mL NS over 1 hour. Observe for 30 minutes post infusion.

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

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>trastuzumab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DOCEtaxel 100 mg/m² x BSA = _______mg

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

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

☐ Cycle # 6:

trastuzumab 6 mg/kg x _____ kg = ________mg IV in 250 mL NS over NS over 30 minutes. Observe for 30 minutes post infusion.

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

<table>
<thead>
<tr>
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<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>trastuzumab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DOCEtaxel 100 mg/m² x BSA = _______mg

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

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

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

**DOCTOR’S SIGNATURE:**

UC SIGNATURE:
DATE:

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Return in <strong>three</strong> weeks for Doctor and Cycle _________</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in <strong>three</strong> weeks for Doctor and BRAJTR (to continue single agent trastuzumab)</td>
</tr>
<tr>
<td>CBC &amp; Diff, Platelets prior to each cycle</td>
</tr>
<tr>
<td>Prior to <strong>Cycle 4</strong>: Bilirubin, ALT, Alk Phos</td>
</tr>
<tr>
<td>If clinically indicated:</td>
</tr>
<tr>
<td>☐ Tot. Prot  ☐ Albumin  ☐ Bilirubin  ☐ GGT  ☐ Alk Phos</td>
</tr>
<tr>
<td>☐ LDH  ☐ ALT  ☐ Creatinine</td>
</tr>
<tr>
<td>☐ Other tests:</td>
</tr>
<tr>
<td>☐ MUGA scan or Echo: prior to Cycle 1 and 4 and then every ☐ 3 months or ☐ 4 months until completion of treatment</td>
</tr>
<tr>
<td>☐ Consults:</td>
</tr>
<tr>
<td>☐ See general orders sheet for additional requests.</td>
</tr>
</tbody>
</table>

**DOCTOR'S SIGNATURE:**

**UC SIGNATURE:**