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**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht_________ cm Wt_________ kg BSA_________ m²</th>
</tr>
</thead>
</table>

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

<table>
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<tr>
<th>DATE:</th>
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<th>Cycle #:</th>
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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 ________________.

Select ONE of the following routine antiemetics regimens:

- **Ondansetron 8 mg PO 30 to 60 minutes prior to FEC treatment**
- **Dexamethasone 8 mg or 12 mg** (circle one) PO 30 to 60 minutes prior to FEC treatment
- **Netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior FEC to treatment**
- **Dexamethasone 8 mg or 12 mg** (circle one) PO 30 to 60 minutes prior FEC to 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.

**Have Hypersensitivity Reaction Tray and Protocol Available**

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

- **Epirubicin 100 mg/m² x BSA = __________mg**
  - Dose Modification: ________% = __________ mg/m² x BSA = __________ mg
  - IV push

- **Fluorouracil 500 mg/m² x BSA = __________mg**
  - Dose Modification: ________% = __________ mg/m² x BSA = __________ mg
  - IV push

- **Cyclophosphamide 500 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 PAGE 2 FOR CHEMOTHERAPY CYCLES 4 TO 6 ***

**DOCTOR’S SIGNATURE:**

**UC SIGNATURE:**

BC Cancer Provincial Preprinted Order BRAJFECDT
Created: 01 Mar 2011 Revised: 1 Feb 2020
## DOCTOR'S ORDERS

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### 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
    - **Drug** | **Brand (Pharmacist to complete. Please print.)** | **Pharmacist Initial and Date**
    - trastuzumab |
  - **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
    - **Drug** | **Brand (Pharmacist to complete. Please print.)** | **Pharmacist Initial and Date**
    - trastuzumab |
  - **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
    - **Drug** | **Brand (Pharmacist to complete. Please print.)** | **Pharmacist Initial and Date**
    - trastuzumab |
  - **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:**

**RETURN APPOINTMENT ORDERS**

- Return in **three** weeks for Doctor and Cycle _________
- Last Cycle. Return in **three** weeks for Doctor and **BRAJTR** (to continue single agent trastuzumab)

**CBC & Diff, Platelets** prior to each cycle

Prior to **Cycle 4:** Bilirubin, **ALT**, Alk Phos

If clinically indicated:
- Tot. Prot
- Albumin
- Bilirubin
- GGT
- Alk Phos
- LDH
- ALT
- Creatinine

- Other tests:
- **MUGA scan or Echo:** prior to Cycle 1 and 4 and then every □ 3 months or □ 4 months until completion of treatment
- **Consults:**
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**UC SIGNATURE:**