PROTOCOL CODE: BRAJPNCT

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:

Number of DOCEtaxel doses completed to date: _____

Number of trastuzumab doses completed to date: _____

☐ Delay Treatment _____ week(s)

☐ **CBC & Diff** 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, total bilirubin less than or equal to 1.5 x ULN, AST or ALT less than or equal to 10 x ULN**

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** (select one) PO 30 to 60 minutes prior to CARBOplatin

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin, and **ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

☐ Patients who have received only ONE cycle of trastuzumab previously

trastuzumab 6 mg/kg x _____ 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

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

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

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 and beyond *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: BRAJPNCT

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

TREATMENT: (Continued)

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

OR

☐ Patients who have received TWO cycles or more of trastuzumab previously

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

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

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

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

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

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

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____.

☐ Book filgrastim (G-CSF) SC teaching and first dose on Cycle ____ Day ____

☐ Last Cycle. Return in **three** weeks for Doctor and BRAJTR (for single agent trastuzumab).

CBC and Diff, total bilirubin, ALT, creatinine prior to each cycle

MUGA scan or Echocardiogram every ☐ 3 months or ☐ 4 months from onset of trastuzumab and upon completion of treatment

If clinically indicated: ☐ **alkaline phosphatase** ☐ **GGT** ☐ **urea**
☐ **Echocardiogram** ☐ **MUGA scan**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: