BC CANCER
Provincial Health Services Authority

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 and according to acceptable standards of care

PROTOCOL CODE: BRAJPNT

DOCTOR'S ORDERS

Ht__________**cm** **Wt**__________**kg** **BSA**__________**m²**

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 PACLitaxel or DOCEtaxel doses completed to date: ________________

Number of trastuzumab doses completed to date: ________________

☐ 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 ____________________________.

☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ 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/m² x BSA = ___________mg

☐ Dose Modification: ___________mg/m² 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)

***** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 and beyond *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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

CHEMOTHERAPY: (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)

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

RETURN APPOINTMENT ORDERS

☐ Return in **<u>three</u>** weeks for Doctor and Cycle _________

☐ Last Cycle. Return in ____________weeks.

CBC & Diff, Platelets 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: ☐ **bilirubin** ☐ **alkaline phosphatase** ☐ **ALT** ☐ **GGT**
☐ **creatinine** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: