PROTOCOL CODE: BRAVPTRAD

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:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff, platelets** day of treatment
If ordered, may proceed with doses as written if within 96 hrs **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 _____.
dexamethasone 8 mg PO bid for 3 days, starting one day prior to DOCEtaxel treatment; 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**
DAY 1
PERTuzumab 840 mg IV in 250 mL NS over 1 hour. Observe for 1 hour post-infusion
DAY 2
trastuzumab (HERCEPTIN) 8 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes
Observe for 1 hour post infusion. Do not substitute HERCEPTIN with trastuzumab biosimilar.
DOCEtaxel 75 mg/m^2 x BSA =_____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (use non-DEHP bag) over 1 hour (use non-DEHP tubing)

OR

☐ **CYCLE # 2**
PERTuzumab 420 mg IV in 250 mL NS over 1 hour. Observe for 30 minutes to 1 hour post infusion.
trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in NS 250 mL over NS over 1 hour. Observe for 30 minutes post infusion. Do not substitute HERCEPTIN with trastuzumab biosimilar.
DOCEtaxel 75 mg/m^2 x BSA =_____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (use non-DEHP bag) over 1 hour. (Use non-DEHP tubing)

***** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 3 to 8*****

DOCTOR SIGNATURE:	UC SIGNATURE:

DOCTOR'S ORDERS (Page 2 of 2)

DATE:

CHEMOTHERAPY: (Continued)

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

OR

☐ **CYCLE # _____ (Cycle 3 to 8)**

PERTuzumab 420 mg IV in 250 mL NS over 30 minutes. Observe for 30 minutes to 1 hour post infusion.*

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes. Observe for 30 minutes post infusion*. Do not substitute HERCEPTIN with trastuzumab biosimilar.

DOCEtaxel 75 mg/m^2 x BSA =_____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

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

OR

☐ **CYCLE #_____ (PERTuzumab and trastuzumab only)**

PERTuzumab 420 mg IV in 250 mL NS over 30 minutes.

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes.

*Observation period not required after 3 treatments with no reaction. Do not substitute HERCEPTIN with trastuzumab biosimilar.

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

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle_____.

☐ Return in _____ weeks for Doctor and Cycle(s) _____.

☐ Last Cycle. Return in _____weeks.

Prior to cycles containing docetaxel (i.e., **cycles 1 to 9 only): CBC & Diff, Platelets**

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

☐ **CBC & Diff, platelets**

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.**
☐ **LDH** ☐ **ALT** ☐ **BUN** ☐ **Creatinine**
☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Other tests:** ☐ **ECG**

☐ **Consults:**

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

DOCTOR SIGNATURE:

UC SIGNATURE: