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:

☐ Delay treatment _________ week(s)

☐ CBC & Diff, platelets day of treatment

If ordered, may proceed with doses as written if within 24 hrs ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 90 x 10⁹/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 ________________________________.

45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in NS 50 mL over 15 minutes

30 Minutes Prior to PACLitaxel: diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)

☐ Other:

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY:

☐ 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.

PACLtaxel 175 mg/m² OR 150 mg/m² (circle one) x BSA = _________ mg

☐ Dose Modification: _________ % = _________ mg/m² x BSA = ___________ mg

IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

OR

☐ CYCLE # ________ (Cycle 2 to 8)

PERTuzumab 420 mg IV in 250 mL NS. Administer cycle 2 over 1 hour. Observe for 30 minutes to 1 hour post infusion.

Cycle 3 onwards: Administer 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 to 1 hour

Observe for 30 minutes post infusion.*

PACLtaxel 175 mg/m² OR 150 mg/m² (circle one) x BSA = _________ mg

☐ Dose Modification: _________ % = _________ mg/m² x BSA = ___________ mg

IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

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.

acetaminophen 325 to 650 mg PO PRN for headache and rigors

DOCTOR SIGNATURE: UC SIGNATURE:
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<th>DOCTOR'S ORDERS</th>
<th>SIGNATURE:</th>
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<tr>
<td>DATE:</td>
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<tr>
<td>RETURN APPOINTMENT ORDERS</td>
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<tr>
<td>☐ Return in <strong>three</strong> weeks for Doctor and Cycle____________________</td>
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<td>☐ Last Cycle. Return in ______ weeks.</td>
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<tr>
<td>Prior to cycles containing <strong>PACLitaxel</strong> (i.e., <strong>cycles 1 to 9 only</strong>): CBC &amp; Diff, Platelets</td>
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<td>Prior to <strong>Cycle 4</strong>: Bilirubin, ALT, GGT, alk phos</td>
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<td>☐ CBC &amp; Diff, platelets</td>
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<tr>
<td>If clinically indicated: ☐ Tot. Prot ☐ Albumin ☐ Bilirubin ☐ GGT ☐ Alk Phos.</td>
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<tr>
<td>☐ LDH ☐ ALT ☐ BUN ☐ Creatinine</td>
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<td>☐ Echocardiogram ☐ MUGA Scan</td>
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<td>☐ See general orders sheet for additional requests.</td>
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