**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**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 $1.5 \times 10^9$/L, Platelets greater than or equal to $90 \times 10^9$/L

**Dose modification for:**

☐ Hematology

☐ Other Toxicity

**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:

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

**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

  **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**

- **Trastuzumab (HERCEPTIN) 8 mg/kg x ______ kg = ________mg** IV in NS 250 mL over 1 hour.

**DAY 2**

- **PACLItaxel 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.)

**DAY 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.

**DAY 2**

- **PACLItaxel 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.)

**DOCTOR SIGNATURE:**

**UC SIGNATURE:**
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: BRAVPTRAT

<table>
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<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
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</table>

**CHEMOTHERAPY: (Continued)**

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

**OR**

- **CYCLE # 3 (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*.
- **PACLItaxel 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

**RETURN APPOINTMENT ORDERS**

- □ Return in three weeks for Doctor and Cycle___________
- □ Last Cycle. Return in _________ weeks.

Prior to cycles containing PACLItaxel (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:**

**SIGNATURE:**

**UC:**