# PROTOCOL CODE: BRAVPTRVIN



## 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

May proceed with doses as written on **Day 1** if within 96 hours **ANC greater than or equal to 1.0 x $10^9$/L, Platelets greater than or equal to 100 x $10^9$/L**

May proceed with doses as written on **Day 8** if within 24 hours **ANC greater than or equal to 1.0 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 _____.

☐ **prochlorperazine 10 mg** PO or ☐ **metoclopramide 10 mg** PO prior to treatment

☐ **hydrocortisone 100 mg** IV in 50 mL NS over 20 minutes pre-vinorelbine (for patients who have had phlebitis)

☐ **Other:**

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

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

☐ **CYCLE # 1**

**PERTuzumab 840 mg** IV in 250 mL NS over 1 hour on **Day 1**. Observe for 1 hour post-infusion

**vinorelbine 25 mg/$m^2$/day** x BSA = _____ mg

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

IV in NS 50 mL over 6 minutes on **Day 1 and Day 8.** Flush vein with NS 75 to 125 mL following infusion.

**trastuzumab 8 mg/kg** x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes on **Day 2**.

Observe for 1 hour 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 | | |

***SEE PAGE 2 FOR CHEMOTHERAPY CYCLE 2 onwards***

**DOCTOR SIGNATURE:**

**UC SIGNATURE:**

## DOCTOR'S ORDERS

**DATE:**

## CHEMOTHERAPY: (Continued)

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

***OR***

☐ **CYCLE # 2**

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

**trastuzumab 6 mg/kg** x _____ kg =_____mg IV in NS 250 mL over NS over 1 hour on **Day 1**.

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 | | |

**vinorelbine** ☐ **30 mg/m²/day** or ☐ **35 mg/m²/day** (select one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 1 and Day 8.** Flush vein with NS 75 to 125 mL following infusion.

**DOSE MODIFICATION DAY 8:**

**vinorelbine 30 mg/m²/day** x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 8.** Flush vein with NS 75 to 125 mL following infusion.

***OR***

☐ **CYCLE # _____ (Cycle 3 to 8)**

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

**trastuzumab 6 mg/kg** x _____ kg =_____mg IV in NS 250 mL over NS over 30 minutes on **Day 1**.

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 | | |

**vinorelbine** ☐ **30 mg/m²/day** or ☐ **35 mg/m²/day** (select one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 1 and Day 8.** Flush vein with NS 75 to 125 mL following infusion.

**DOSE MODIFICATION DAY 8:**

**vinorelbine 30 mg/m²/day** x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 8.** Flush vein with NS 75 to 125 mL following infusion.

*Observation period not required after 3 treatments with no reaction.

*****SEE PAGE 3 FOR CHEMOTHERAPY CYCLE 9 onwards*****

| **DOCTOR SIGNATURE:** | **SIGNATURE:**<br>**UC:** |
|---|---|

## DOCTOR'S ORDERS

**DATE:**

### CHEMOTHERAPY: (Continued)

***** SEE PAGES 1 and 2 FOR CHEMOTHERAPY CYCLES 1 to 8 *****

***OR***

☐ **CYCLE #_____ (PERTuzumab and trastuzumab only)** every ☐ **three** or ☐ **four** weeks (select one)

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

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

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 | | |

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

## RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle_____. Book chemo Day 1 and 8 (Cycles 1 to 8 only).

☐ Return in **three** or **four** weeks (circle one) for Doctor and Cycle_____. Book chemo Day 1

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

☐ Last Cycle. Return in _____ weeks.

Prior to each vinorelbine and the first cycle of PERTuzumab and trastuzumab only (i.e., **cycles 1 to 9 only**): **CBC & Diff, Platelets**

☐ **CBC & Diff, platelets**

If clinically indicated: ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos** ☐ **ALT** ☐ **LDH**
☐ **Creatinine** ☐ **BUN** ☐ **albumin** ☐ **CA 15-3**
☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Other tests:** ☐ **ECG**

☐ **Consults:**

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

**DOCTOR SIGNATURE:**

**SIGNATURE:**

**UC:**