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/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**DOCTOR’S ORDERS**

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

May proceed with doses as written if within 96 hours ANC **greater than or equal to** 1.5 x 10⁹/L, Platelets **greater than** 90 x 10⁹/L

Dose modification for:

☐ Hematology

☐ Other Toxicity

Proceed with treatment based on blood work from __________

**PREMEDICATIONS:**

45 minutes prior to PACLitaxel:

- Dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

- DiphenhydrAMINE 50 mg IV and Ranitidine 50 mg IV in 50 mL NS over 20 minutes

(Compatible up to 3 hours when mixed in bag)

**Have Hypersensitivity Reaction Tray and Protocol Available**

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

☐ CYCLE #1 DAY 1

trastuzumab 8 mg/kg x _______ kg =________mg IV in NS 250 mL over 1 hour 30 minutes. Observe for 1 hour post infusion.

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
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CYCLE #1 DAY 2

PACLitaxel 175 mg/m² =_________ mg

☐ Dose Modification: _______ mg/m² x BSA = ___________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 6***

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
CHEMOTHERAPY: (Continued) **SEE PAGE 1 FOR CHEMOTHERAPY CYCLE 1**

OR

☐ Cycle 2

trastuzumab 6 mg/kg x ________ kg =_________mg IV in NS 250 mL over NS over 1 hour. Observe for 30 minutes post infusion. Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

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PACLitaxel 175 mg/m² =_________ mg

☐ Dose Modification: ________ mg/m² x BSA = ___________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

OR

☐ Cycle 3 and Subsequent: (Cycles 3 to 6)

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

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PACLitaxel 175 mg/m² x BSA =_________ mg

☐ Dose Modification: ________ mg/m² x BSA = ___________ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

acetaminophen 325 mg – 650 mg PO PRN for headache and rigors

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle ________.

☐ Last Cycle. Return in ___________ weeks.

CBC & Diff, Platelets prior to each cycle

If clinically indicated: ☐ Total Bilirubin ☐ ALT

☐ Other tests: ☐ ECG ☐ Echocardiogram ☐ MUGA Scan

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE: SIGNATURE:

UC: