PROTOCOL CODE: BRAVTRVIN

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 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**

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 to 20 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:**

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **Cycle 1 ONLY**

trastuzumab 8 mg/kg x _____ kg = _____mg IV in NS 250 mL over 1 hour 30 minutes on Day 1 only. Observe for 60 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 ☐ **35 mg/m^2/day** or ☐ **30 mg/m^2/day** (select one) x BSA = _____ mg

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

☐ **Cycle 2 ONLY**

trastuzumab 6 mg/kg x _____kg = _____mg IV in NS 250 mL over 1 hour on Day 1 only. 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 ☐ **35 mg/m^2/day** or ☐ **30 mg/m^2/day** (select one) x BSA = _____ mg

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

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DOCTOR'S ORDERS

DATE:

Chemotherapy: (Continued)

☐ **Cycle 3 onwards**

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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

vinorelbine ☐ **35 mg/m²/day** or ☐ **30 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.

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

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.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. Book chemo Day 1 and 8.

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to each treatment

If clinically indicated: ☐ **Creatinine** ☐ **Bilirubin** ☐ **ALT** ☐ **Alk Phos** ☐ **GGT**

☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: