# DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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**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:** Patient to take own supply. RN/Pharmacist to confirm ______________________________.

dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment

and select ONE of the following:

- **ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
- **aprepitant 125 mg** PO 30 to 60 minutes prior to AC treatment on Day 1, then **80 mg** PO daily on Day 2 and 3
- **ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
- **netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to AC treatment

As needed antiemetics:
- **prochlorperazine 10 mg** PO prn
- **metoclopramide 10 mg** PO prn

**For DOCEtaxel Cycles:** dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment

**Optional:** Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

- **Other:**

**Have Hypersensitivity Reaction Tray and Protocol Available**

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

- **CYCLE #________ (Cycle 1-4)**

  - **DOXOrubicin 60 mg/m² x BSA = _____________mg**
    - **Dose Modification:** ______ % = ______ mg/m² x BSA = _____________ mg
      - IV push
  - **cyclophosphamid 600 mg/m² x BSA = _____________mg**
    - **Dose Modification:** ______ % = ______ mg/m² x BSA = _____________ mg
      - IV in 100 to 250 mL NS over 20 minutes to 1 hour

**SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8**

**DOCTOR’S SIGNATURE:**

**UC SIGNATURE:**
### DOCTOR'S ORDERS

**DATE:**

**To be given:**

**Cycle #:**

### CHEMOTHERAPY: (Continued)

*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 4 ***

- **CYCLE # 5** (Cycle 1 of trastuzumab/DOCEtaxel)
  - **Trastuzumab 8 mg/kg**
  - \(\times \) _______ 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

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- **DOCEtaxel 100 mg/m²**
  - \(\times \) BSA = _______ mg
  - Dose Modification: _______% = ________ mg/m² \(\times \) BSA = __________ mg

  - IV in NS 250 to 500 mL (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

- **CYCLE # 6**
  - **Trastuzumab 6 mg/kg**
  - \(\times \) _______ kg = _________mg IV in NS 250 mL 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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- **DOCEtaxel 100 mg/m²**
  - \(\times \) BSA = _______ mg
  - Dose Modification: _______% = ________ mg/m² \(\times \) BSA = __________ mg

  - IV in NS 250 to 500 mL (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

- **CYCLE # 7 and # 8:**
  - **Trastuzumab 6 mg/kg**
  - \(\times \) _______ 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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- **DOCEtaxel 100 mg/m²**
  - \(\times \) BSA = _______ mg
  - Dose Modification: _______% = ________ mg/m² \(\times \) BSA = __________ mg

  - IV in NS 250 to 500 mL (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

**Acetaminophen**

- 325 to 650 mg PO PRN for headache and rigors

**DOCTOR'S SIGNATURE:**

**UC SIGNATURE:**
**RETURN APPOINTMENT ORDERS**

| Return in three weeks for Doctor and Cycle _________ |
| Return in three weeks for BRAJTR (to continue single agent trastuzumab) |
| CBC & Diff, Platelets prior to each cycle |
| Prior to **Cycle 5**: Bilirubin, ALT, Alk Phos |
| If clinically indicated: |
| ☐ Tot. Prot  ☐ Albumin  ☐ Bilirubin  ☐ GGT  ☐ Alk Phos. |
| ☐ LDH  ☐ ALT  ☐ Creatinine |
| ☐ Other tests: |
| ☐ MUGA scan or Echo: prior to Cycle 5 and then every ☐ 3 months or ☐ 4 months until completion of treatment |
| ☐ Consults: |
| ☐ See general orders sheet for additional requests. |

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