A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

**DOCTOR’S ORDERS**

Ht________cm Wt________kg BSA________m²

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 24 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 10 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes

(Compatible up to 3 hours when mixed in bag)

☐ No pre-medication to PACLitaxel required (see protocol for guidelines)

☐ Other:

**Have Hypersensitivity Reaction Tray and Protocol Available**

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

☐ CYCLE #1, Week 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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<tr>
<td>trastuzumab</td>
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CYCLE #1, Week 1, Day 2

PACLitaxel 80 mg/m² OR ________ mg/m² (circle one) x BSA = ____________ mg

☐ Dose Modification: ________% = ________ mg/m² x BSA = ____________ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

☐ CYCLE #1, Weeks 2 and 3

PACLitaxel 80 mg/m² OR ________ mg/m² (circle one) x BSA = ____________ mg

☐ Dose Modification: ________% = ________ mg/m² x BSA = ____________ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 2 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 4***

**DOCTOR’S SIGNATURE:**

BC Cancer Provincial Preprinted Order UBRAJTTW

Created: 01 Dec 2017 Revised: 1 Feb 2020 (Biosimilar section added)
**DOCTOR’S ORDERS**

**DATE:**

**CHEMOTHERAPY: (Continued)**

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

☐ CYCLE # 2

trastuzumab 6 mg/kg x _______ kg =_________mg IV in NS 250 mL over NS over 1 hour once every 3 weeks. Observe for 30 minutes post infusion.

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

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PACLitaxel 80 mg/m² OR _______ mg/m² (circle one) x BSA = _________ mg

☐ Dose Modification: _______ % = ________ mg/m² x BSA = _________ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

☐ CYCLE # 3 and 4

trastuzumab 6 mg/kg x _______ kg =_________mg IV in NS 250 mL over NS over 30 minutes once every 3 weeks. 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 80 mg/m² OR _______ mg/m² (circle one) x BSA = _________ mg

☐ Dose Modification: _______ % = ________ mg/m² x BSA = _________ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

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

**DOCTOR’S SIGNATURE:**

UC

**SIGNATURE:**
## RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _________. (Book chemo room weekly x 12 weeks, then **switch to BRAJTR**).
- Last Cycle. Return in **three** weeks for Doctor and BRAJTR (to continue single agent trastuzumab).

<table>
<thead>
<tr>
<th>CBC &amp; Diff, Platelets</th>
<th>prior to each weekly dose</th>
</tr>
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<tbody>
<tr>
<td>✓ Total Bilirubin</td>
<td>☐ ALT</td>
</tr>
</tbody>
</table>

- Other tests: ☐ ECG  ☐ Echocardiogram  ☐ MUGA Scan

- Consults:
- ☐ See general orders sheet for additional requests.

## DOCTOR'S SIGNATURE:

| UC |
| SIGNATURE: |