PROTOCOL CODE: UBRAJTTW

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

DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
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</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 24 hours ANC greater than or equal to $1.5 \times 10^9$/L, Platelets greater than $90 \times 10^9$/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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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:  UC SIGNATURE:

BC Cancer Provincial Preprinted Order UBRAJTTW
Created: 01 Dec 2017 Revised: 1 Mar 2020 (RTC booking wording changed)
## DOCTOR'S ORDERS

### CHEMOTHERAPY: (Continued)

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**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:

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### RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _________. *(Book chemo room weekly x 3 for cycles 1 – 4, then switch to BRAJTR).*
- Last Cycle. Return in **three** weeks for Doctor and BRAJTR (to continue single agent trastuzumab).

- **CBC & Diff, Platelets** prior to each weekly dose
- If clinically indicated:  
  - ☐ **Total Biliirubin**  
  - ☐ **ALT**
- ☐ **Other tests:**  
  - ☐ **ECG**  
  - ☐ **Echocardiogram**  
  - ☐ **MUGA Scan**
- ☐ **Consults:**
- ☐ **See general orders sheet for additional requests.**

### DOCTOR’S SIGNATURE:

| UC |
| SIGNATURE: |

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