**PROTOCOL CODE: UBRAVKAD**

A BCCA “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>
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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 x 10⁹/L and Platelets **greater than or equal to** 75 x 10⁹/L

Dose modification for:
- Hematology
- Renal Function
- Other Toxicity

Proceed with treatment based on blood work from ________

### PREMEDICATIONS:

- Patient to take own supply. RN/Pharmacist to confirm ____________________________.
- prochlorperazine 10 mg PO prior to treatment
- metoclopramide 10 to 20 mg PO prior to treatment
- Other:

### CHEMOTHERAPY:

| trastuzumab emtansine (KADCYLA) 3.6 mg/kg x ________ kg = ________ mg |

- Dose Modification: ________ mg/kg x ________ kg = ________ mg

IV in 250 mL NS (use in-line filter) over 1 h 30 min. Observe for 1 hour 30 minutes post infusion. If no infusion reaction observed in Cycle 1, may administer subsequent cycles over 30 minutes, observe for 30 minutes post-infusion.

### RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle ________.
- Last Cycle. Return in ________ weeks.

CBC & Diff, platelets, bilirubin, LFTs prior to each cycle

If clinically indicated:
- Tot. Prot
- Albumin
- Electrolytes
- Bilirubin
- GGT
- Alk Phos.
- AST
- LDH
- ALT
- BUN
- Creatinine
- Echocardiogram
- MUGA Scan

- Other Tests: ECG
- Consults:
- See general orders sheet for additional requests.

### DOCTOR’S SIGNATURE: ____________________________

SIGNATURE: ____________________________

UC: ____________________________