**PROTOCOL CODE: UBRAVTCAP**

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment.

<table>
<thead>
<tr>
<th>DOCTOR'S ORDERS</th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

- 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 or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/min.

Dose modification for:

- □ Hematology
- □ Other Toxicity

Proceed with treatment based on blood work from ___________________________

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm _____________________________.

- □ Other:

****Have Hypersensitivity Reaction Tray and Protocol Available**

**CHEMOTHERAPY:**

- trastuzumab (HERCEPTIN) 6 mg/kg x _______ kg =_________mg IV in 250 mL NS over 30 minutes on Day 1

- capecitabine 1250 mg/m² or 1000 mg/m² (circle one) x BSA x (_______%) = _________mg PO BID with food x 14 days on days 1 – 14. (Round dose to nearest 150 mg)

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

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**RETURN APPOINTMENT ORDERS**

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

**CBC & Diff, Platelets, Creatinine prior to each cycle**

- □ INR Weekly
- □ INR prior to each cycle

If clinically indicated:

- □ Tot. Prot
- □ Albumin
- □ Bilirubin
- □ GGT
- □ Alk Phos.
- □ AST
- □ LDH
- □ ALT
- □ BUN

- □ Other tests:
- □ ECG
- □ Echocardiogram
- □ MUGA Scan

- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**