

PROTOCOL CODE: BRAJDCARBT

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DOCTOR'S ORDERS			Ht _____ cm	Wt _____ kg	BSA _____ m ²						
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form											
DATE:		To be given:		Cycle #:							
Date of Previous Cycle:											
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> 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 100 x 10⁹/L											
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____											
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel. Patient must receive 3 doses prior to treatment ondansetron 8 mg PO prior to CARBOplatin treatment <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin 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. <input type="checkbox"/> Other:											
** Have Hypersensitivity Reaction Tray and Protocol Available**											
CHEMOTHERAPY: (Note – continued over 2 pages)											
<input type="checkbox"/> CYCLE 1 only											
trastuzumab 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS 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 border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Drug</th> <th style="width: 40%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td>trastuzumab</td> <td> </td> <td> </td> </tr> </tbody> </table>						Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	trastuzumab		
Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date									
trastuzumab											
DOCEtaxel 75 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).											
CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes.											
*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 TO 6 ***											
DOCTOR'S SIGNATURE:					UC SIGNATURE:						

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DATE:

CHEMOTHERAPY: (Continued)

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

CYCLE 2 only

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in NS 250 mL over 1 hour. 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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCEtaxel 75 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).

CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg

Dose Modification: _____ % = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

CYCLE 3 to 6

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS 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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCEtaxel 75 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing).

CARBOplatin AUC 6 Dose = AUC x (GFR +25) = _____ mg

Dose Modification: _____ % = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

acetaminophen 325 mg to 650 mg PO PRN for headache and rigors.

DOCTOR'S SIGNATURE:

**UC
SIGNATURE:**

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RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ (maximum 6). <input type="checkbox"/> Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day _____ <input type="checkbox"/> Last Cycle. Return in three weeks for Doctor and BRAJTR (for single agent trastuzumab).	
<p>CBC and Diff, Platelets, Creatinine prior to each cycle.</p> <input type="checkbox"/> MUGA scan or <input type="checkbox"/> echocardiogram (select one) prior to Cycle 1 and Cycle 5 and then every <input type="checkbox"/> 3 months or <input type="checkbox"/> 4 months until completion of treatment <p>If clinically indicated on subsequent cycles:</p> <input type="checkbox"/> Bilirubin <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> GGT <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> Alk Phos <p>If clinically indicated: <input type="checkbox"/> Echocardiogram <input type="checkbox"/> MUGA Scan</p> <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general order sheet for additional requests.	
DOCTOR'S SIGNATURE:	UC SIGNATURE: