BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: UBRAJKAD

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

DOCTOR'S ORDERS

Wt___________kg

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** day of treatment
May proceed with doses as written if within 96 hours **ANC <u>greater than or equal</u> to 1.0 x 10^9/L and platelets <u>greater than or equal to</u> 75 x 10^9/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 or ☐ **metoclopramide 10 to 20 mg** PO prior to treatment
☐ **Other:**

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

TREATMENT:

trastuzumab emtansine (KADCYLA) 3.6 mg/kg x ___________kg =__________mg
☐ Dose Modification: ________ mg/kg x __________kg = ___________ mg

IV in 250 mL NS over 90 minutes using a 0.2 micron in-line filter. 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. Observation period not required after 3 treatments with no reaction.

Pharmacist to select **dose band** per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
trastuzumab emtansine (KADCYLA)		

RETURN APPOINTMENT ORDERS

☐ Return in **<u>three</u>** weeks for Doctor and Cycle____.
☐ Last Cycle. Return in __________weeks.

CBC & Diff, total bilirubin, ALT, alkaline phosphatase, LDH, GGT prior to each cycle
MUGA scan or echocardiogram every ☐ 3 months or ☐ 4 months from onset of trastuzumab emtansine (KADCYLA) and upon completion of treatment

If clinically indicated:

☐ **total protein** ☐ **albumin** ☐ **sodium** ☐ **potassium** ☐ **urea** ☐ **creatinine**
☐ **echocardiogram** ☐ **MUGA scan** ☐ **ECG**
☐ **Other Tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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TRASTUZUMAB EMTANSINE (KADCYLA) DOSE BANDING TABLE

Ordered Dose (mg)		Rounded dose (mg)
From:	**To:**	
Less than 80		**Pharmacy prepares specific dose**
80	88.49	**84**
88.5	96.49	**92**
96.5	104.49	**100**
104.5	112.49	**108**
112.5	121.49	**116**
121.5	129.49	**124**
129.5	138.49	**132**
138.5	146.49	**140**
146.5	154.49	**148**
154.5	167.49	**160**
167.5	179.49	**170**
179.5	188.49	**180**
188.5	195.49	**190**
195.5	209.49	**200**
209.5	230.49	**220**
230.5	251.49	**240**
251.5	272.49	**260**
272.5	293.49	**280**
293.5	314.49	**300**
314.5	335.49	**320**
335.5	356.49	**340**
356.5	377.49	**360**
377.5	398.49	**380**
398.5	419.49	**400**
419.5	439.49	**420**
439.5	461.49	**440**
461.5	499.49	**480**
499.5	545.49	**520**
More than 545.49		**Pharmacy prepares specific dose**