

PROTOCOL CODE: BRAVPTRVIN

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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 Cycles 1 to 8: May proceed with doses as written on Day 1 if within 96 hours ANC <u>greater than or equal to</u> 1.0 x 10⁹/L, Platelets <u>greater than or equal to</u> 100 x 10⁹/L May proceed with doses as written on Day 8 if within 24 hours ANC <u>greater than or equal to</u> 1.0 x 10⁹/L, Platelets <u>greater than or equal to</u> 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 _____.										
<input type="checkbox"/> prochlorperazine 10 mg PO or <input type="checkbox"/> metoclopramide 10 mg PO prior to treatment <input type="checkbox"/> hydrocortisone 100 mg IV in 50 mL NS over 20 minutes pre-vinorelbine (for patients who have had phlebitis) <input type="checkbox"/> Other:										
Have Hypersensitivity Reaction Tray and Protocol Available										
CHEMOTHERAPY: (Note – continued over 2 pages)										
<input type="checkbox"/> CYCLE # 1										
PERTuzumab 840 mg IV in 250 mL NS over 1 hour on Day 1 . Observe for 1 hour post-infusion										
vinorelbine 25 mg/m²/day x BSA = _____ mg										
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg										
IV in NS 50 mL over 6 minutes on Day 1 and Day 8 . Flush vein with NS 75 to 125 mL following infusion.										
trastuzumab 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes on Day 2 . 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										
SEE PAGE 2 FOR CHEMOTHERAPY CYCLE 2 onwards										
DOCTOR SIGNATURE:				UC SIGNATURE:						

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DOCTOR'S ORDERS

DATE:

CHEMOTHERAPY: (Continued)

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

OR

CYCLE # 2

PERTuzumab 420 mg IV in 250 mL NS over 1 hour on **Day 1**. Observe for 30 minutes to 1 hour post infusion.

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

Observe for 30 minutes post infusion.

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		

vinorelbine **30 mg/m²/day** or **35 mg/m²/day** (select one) x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 1 and Day 8**. Flush vein with NS 75 to 125 mL following infusion.

DOSE MODIFICATION DAY 8:

vinorelbine 30 mg/m²/day x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 8**. Flush vein with NS 75 to 125 mL following infusion.

OR

CYCLE # _____ (Cycle 3 to 8)

PERTuzumab 420 mg IV in 250 mL NS over 30 minutes on **Day 1**. Observe for 30 minutes to 1 hour post infusion.*

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in NS 250 mL over NS over 30 minutes on **Day 1**.

Observe for 30 minutes post infusion.*

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		

vinorelbine **30 mg/m²/day** or **35 mg/m²/day** (select one) x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 1 and Day 8**. Flush vein with NS 75 to 125 mL following infusion.

DOSE MODIFICATION DAY 8:

vinorelbine 30 mg/m²/day x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in NS 50 mL over 6 minutes **Day 8**. Flush vein with NS 75 to 125 mL following infusion.

*Observation period not required after 3 treatments with no reaction.

SEE PAGE 3 FOR CHEMOTHERAPY CYCLE 9 onwards

DOCTOR SIGNATURE:

SIGNATURE:
UC:

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DOCTOR'S ORDERS

DATE:

CHEMOTHERAPY: (Continued)
*** SEE PAGES 1 and 2 FOR CHEMOTHERAPY CYCLES 1 to 8 ***

OR

CYCLE # _____ (PERTuzumab and trastuzumab only) every **three** or **four** weeks (select one)
PERTuzumab 420 mg IV in 250 mL NS over 30 minutes.

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 30 minutes.

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		

acetaminophen 325 to 650 mg PO PRN for headache and rigors

RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _____. Book chemo Day 1 and 8 (Cycles 1 to 8 only).
- Return in **three** or **four** weeks (circle one) for Doctor and Cycle _____. Book chemo Day 1
- Return in _____ weeks for Doctor and Cycle(s) _____.
- Last Cycle. Return in _____ weeks.

Prior to each vinorelbine (i.e., **cycles 1 to 9 only**): **CBC & Diff, Platelets**

CBC & Diff, platelets

If clinically indicated: **Bilirubin** **GGT** **Alk Phos** **ALT** **LDH**
 Creatinine **BUN** **albumin** **CA 15-3**
 Echocardiogram **MUGA Scan**

Other tests: **ECG**

Consults:

See general orders sheet for additional requests.

DOCTOR SIGNATURE: _____ **SIGNATURE:** _____
UC: _____