PROTOCOL CODE: BRAJFECDT

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:

☐ 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 10^9/L, Platelets greater than or equal to 90 x 10^9/L**
Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

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

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to FEC treatment
and **select** ONE of the following:

☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to FEC treatment
☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to FEC treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to FEC treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to FEC treatment

For DOCEtaxel Cycles: **dexamethasone 8 mg** PO bid for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment
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.

☐ hydrocortisone 100 mg IV PRN
☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 2 pages)
☐ **CYCLE 1-3**

epirubicin 100 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push
fluorouracil 500 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push
cyclophosphamide 500 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour

***** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 4 TO 6 *****

DOCTOR'S SIGNATURE:

UC

SIGNATURE:

DOCTOR'S ORDERS

DATE: **To be given:** **Cycle #:**

CHEMOTHERAPY: (Continued)

***** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 3 *****

OR

☐ **CYCLE # 4** (Cycle 1 of trastuzumab and DOCEtaxel)

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

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

DOCEtaxel 100 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour. (Use non-DEHP tubing)

☐ **CYCLE # 5**

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

DOCEtaxel 100 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

☐ **Cycle # 6:**

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

DOCEtaxel 100 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

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

DOCTOR'S SIGNATURE:

UC

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DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in **three** weeks for Doctor and **BRAJTR** (to continue single agent trastuzumab)	
CBC & Diff, Platelets prior to each cycle Prior to **Cycle 4**: **Bilirubin, ALT, Alk Phos** If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos** ☐ **LDH** ☐ **ALT** ☐ **Creatinine** ☐ **Other tests:** ☐ **MUGA scan or** ☐ **Echo** (select one)**:** prior to Cycle 1 and 4 and then every ☐ 3 months or ☐ 4 months until completion of treatment ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**UC** **SIGNATURE:**