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

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 1.0 x 10^9/L and Platelets greater than or equal to 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****

CHEMOTHERAPY:

trastuzumab emtansine (KADCYLA) 3.6 mg/kg x _____kg =_____mg

☐ Dose Modification: _____ mg/kg x _____kg = _____ mg

IV in 250 mL NS over 1 h 30 min 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.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle____.

☐ Last Cycle. Return in _____weeks.

CBC & Diff, platelets, 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:

☐ **Tot. Prot** ☐ **Albumin** ☐ **sodium** ☐ **potassium** ☐ **Bilirubin** ☐ **ALT**

☐ **Alk Phos.** ☐ **LDH** ☐ **GGT** ☐ **BUN** ☐ **Creatinine**

☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Other Tests:** ☐ **ECG**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: