PROTOCOL CODE: BRAJACTT

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 AC treatment

and **select** ONE of the following:

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

OR

45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 Minutes Prior to PACLitaxel: diphenhydrAMINE 50 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8****

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE #_____ (Cycle 1-4)**

DOXOrubicin 60 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV push

cyclophosphamide 600 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 PAGES 2 and 3 FOR CHEMOTHERAPY CYCLES 5 TO 8 *****

DOCTOR SIGNATURE:	**UC SIGNATURE:**

DOCTOR'S ORDERS

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

CHEMOTHERAPY: (Continued)

OR ☐ **CYCLE # 5 (Cycle 1 of trastuzumab and PACLitaxel)**

DAY 1

trastuzumab 8 mg/kg x _____ kg =_____mg IV in NS 250 mL 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		

DAY 2

PACLitaxel 175 mg/m^2 x BSA =_____ mg

☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)

OR ☐ **CYCLE # 6 DAY 1**

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

PACLitaxel 175 mg/m^2 x BSA =_____ mg

☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)

DOCTOR'S SIGNATURE: **UC SIGNATURE:**

PROTOCOL CODE: BRAJACTT

DOCTOR'S ORDERS (Page 3 of 3)

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

OR ☐ **CYCLE # (Cycle 7, 8) DAY 1**

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

PACLitaxel 175 mg/m^2 x BSA =_____ mg

☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)

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

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle_____ (Book Cycle #5 as Day 1 and 2)

☐ Last Cycle. Return in **three** weeks for BRAJTR (to continue single agent trastuzumab)

CBC & Diff, Platelets prior to each cycle

Muga Scan or Echo prior to Cycle 5 and then every ☐ 3 months or ☐ 4 months until completion of treatment

Prior to **Cycle 5: ALT, Bilirubin**

If clinically indicated : ☐ **Creatinine** ☐ **Muga Scan** ☐ **Echocardiogram**

☐ **ALT** ☐ **Bilirubin**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE: **UC SIGNATURE:**