

PROTOCOL CODE: BRAJPNT

(Page 1 of 2)

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: _____											
Number of PACLitaxel or DOCEtaxel doses completed to date: _____											
Number of trastuzumab doses completed to date: _____											
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> 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 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Bilirubin less than or equal to 1.5 x ULN, AST or ALT less than or equal to 10 x ULN											
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"/> Other: _____											
Have Hypersensitivity Reaction Tray and Protocol Available											
CHEMOTHERAPY: (Note – continued over 2 pages) <input type="checkbox"/> Patients who have received only ONE cycle of trastuzumab previously 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											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Drug</th> <th style="width: 55%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 30%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">trastuzumab</td> <td style="height: 30px;"></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											
PACLitaxel NAB (ABRAXANE) 260 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with 15 micron filter)											
*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 and beyond ***											
DOCTOR'S SIGNATURE:					SIGNATURE:						
					UC:						

