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: BRAJTDC

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 ___________________________.

ondansetron 8 mg PO prior to treatment

dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxe; 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.

☐ **Other:** ___________________________

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

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE # 1**

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		

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

DOCEtaxel 75 mg/m^2 x BSA =________mg

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

IV in 250 to 500 mL NS over 1 hour (use non-DEHP bag and tubing)

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

DOCTOR'S SIGNATURE:

UC SIGNATURE:

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DOCTOR'S ORDERS

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

CHEMOTHERAPY: (Continued)

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

☐ **CYCLE # 2**

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		

cyclophosphamide 600 mg/m^2 x BSA = ________mg
☐ Dose Modification: ________% = ________ mg/m^2 x BSA = ___________ mg
IV in NS 100 to 250 mL over 20 minutes to 1 hour

DOCEtaxel 75 mg/m^2 x BSA =_______mg
☐ Dose Modification: ________% = ________ mg/m^2 x BSA = ___________ mg
IV in NS 250 to 500 mL over 1 hour (use non-DEHP bag and tubing)

☐ **CYCLES # 3-4:**

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 reactions)

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		

cyclophosphamide 600 mg/m^2 x BSA = ________mg
☐ Dose Modification: ________% = ________ mg/m^2 x BSA = ___________ mg
IV in NS 100 to 250 mL over 20 minutes to 1 hour

DOCEtaxel 75 mg/m^2 x BSA =_______mg
☐ Dose Modification: ________% = ________ mg/m^2 x BSA = ___________ mg
IV in NS 250 to 500 mL NS over 1 hour (use non-DEHP bag and tubing)

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

DOCTOR'S SIGNATURE:	UC SIGNATURE:

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RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle ________ ☐ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day ________ ☐ 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 1: **Creatinine, Bilirubin, Alk Phos, ALT** Prior to Subsequent Cycles if clinically indicated: ☐ **Bilirubin** ☐ **Creatinine** ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **LDH** ☐ **ALT** ☐ **Alk Phos** ☐ **BUN** ☐ **Other tests:** ☐ **MUGA scan or Echo:** Prior to Cycle 1 and every then every ☐ 3 months or ☐ 4 months during trastuzumab treatment ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**UC SIGNATURE:**