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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: BRAJTR

DOCTOR'S ORDERS

Ht___________**cm** **Wt**___________**kg** **BSA**___________**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

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

Date of Previous Cycle:

Indicate the number of trastuzumab doses patient has received together with chemotherapy (not as single agent) to date: ____________________

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

TREATMENT:

☐ **Cycle 1 Only (NEW patients ONLY – Omit for patients continuing single-agent trastuzumab following a trastuzumab-containing chemotherapy regimen**)

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		

OR

☐ **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		

☐ **Cycle 3 and subsequent:**

trastuzumab 6 mg/kg x _______ kg = _______ mg IV in NS 250 mL over 30 minutes x ____ cycle(s). 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		

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

Proceed with treatment based on blood work from ____

DOCTOR'S SIGNATURE:	UC SIGNATURE:

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RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _________. ☐ Return in _________ weeks for Doctor and Cycle(s) _________. ☐ Last Cycle. Return in ___________weeks.	
MUGA Scan or Echocardiogram every ☐ 3 months or ☐ 4 months from onset of trastuzumab and upon completion of treatment If clinically indicated x _______weeks: ☐ **CBC & Diff, platelets** prior to next treatment ☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **CA15-3** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos** ☐ **ALT** ☐ **LDH** ☐ **Creatinine** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**UC SIGNATURE:**