PROTOCOL CODE: BRAVTR

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 # 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 (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 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		

OR

☐ **Cycle 2**
trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS 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: (For patients who have just completed a trastuzumab-containing chemotherapy regimen)**
trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes**
every ☐ **three** or ☐ **four** weeks (select one) x _____ cycle(s). 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		

* Observation period not required after 3 treatments with no reaction
** 30 minute infusion time for Cycle 3 and all subsequent cycles, if no previous adverse reactions.
acetaminophen 325 to **650 mg** PO PRN for headache and rigors
Proceed with treatment based on blood work from _____

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

PROTOCOL CODE: BRAVTR

DOCTOR'S ORDERS	**Ht**_____**cm** **Wt**_____**kg** **BSA**_____**m²**
DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** or **four** weeks for Doctor and Cycle _____. ☐ Return in _____ weeks for Doctor and Cycle(s) _____.	
CBC & Diff, platelets prior to Cycle #2 ☐ **CBC & Diff, platelets every 12 weeks** If clinically indicated x _____weeks: ☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **CA15-3** ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.** ☐ **LDH** ☐ **ALT** ☐ **BUN** ☐ **Creatinine** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**