PROTOCOL CODE: BRLAACDT

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

For DOCEtaxel Cycles: **dexamethasone 8 mg** PO bid for 3 days starting one day prior to DOCEtaxel; 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 #_____ (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 PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8 *****

DOCTOR'S SIGNATURE:

UC SIGNATURE:

PROTOCOL CODE: BRLAACDT

DOCTOR'S ORDERS

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

CHEMOTHERAPY: (Continued)

***** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 4 *****

☐ **CYCLE # 5** (Cycle 1 of trastuzumab/DOCEtaxel)

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		

DOCEtaxel 100 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 1 hour (Use non-DEHP tubing)

☐ **CYCLE # 6**

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		

DOCEtaxel 100 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 1 hour (Use non-DEHP tubing)

☐ **CYCLE # 7 and # 8:**

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		

DOCEtaxel 100 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 1 hour (Use non-DEHP tubing)

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

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

PROTOCOL CODE: BRLAACDT

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in **three** weeks for BRAJTR (to continue single agent trastuzumab)	
CBC & Diff, Platelets prior to each cycle Prior to **Cycle 5**: **Bilirubin, ALT, Alk Phos** If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.** ☐ **LDH** ☐ **ALT** ☐ **Creatinine** ☐ **Other tests:** ☐ **MUGA scan or** ☐ **Echo** (select one)**:** prior to Cycle 5 and then every ☐ 3 months or ☐ 4 months until completion of treatment ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**UC SIGNATURE:**