BC Cancer Agency
CARE & RESEARCH

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAJTR

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

trastuzumab (HERCEPTIN) 8 mg/kg x _____ kg =_____mg IV in NS 250 mL over 1 hour 30 minutes. Observe for 1 hour post-infusion.

OR

☐ **Cycle 2**

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in NS 250 mL over 1 hour. Observe for 30 minutes post-infusion.

☐ **Cycle 3 and subsequent (maximum 17 cycles total including previous adjuvant chemotherapy containing trastuzumab:**

trastuzumab (HERCEPTIN) 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).

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

Proceed with treatment based on blood work from _____

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 (17 cycles).

If clinically indicated x _____weeks:

☐ **CBC & Diff, platelets** prior to next treatment
☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan**
☐ **CA15-3** ☐ **LFTs** ☐ **Creatinine**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:
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