



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: BRAVTPCARB

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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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, platelets day of treatment				
May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $90 \times 10^9/L$				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity				
Proceed with treatment based on blood work from _____				
PREMEDICATIONS: 45 minutes prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL NS over 15 minutes 30 minutes prior to PACLitaxel: diphenhydramine 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes (Compatible up to 3 hours when mixed in bag) ondansetron 8 mg PO 30 minutes prior to CARBOplatin				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY: DAY 1, CYCLE #1 trastuzumab (HERCEPTIN) 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion* DAY 2, CYCLE #1 PACLitaxel 175 mg/m^2 x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m^2 x BSA = _____ mg IV in 250 to 500 mL (use non-DEHP bag) NS over 3 hours (use Non DEHP tubing with 0.22 micron or smaller in-line filter) CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 250 mL NS over 30 minutes OR DAY 1, CYCLE # 2 to 6 trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS**. Observe for 30 minutes post infusion*, then start Paclitaxel premedications. *observation period not required after 3 treatments with no reaction (ie Cycle 4 onwards) ** Over 1 hour for cycle 2; over 30 minutes for cycle 3 and all subsequent cycles, if no previous adverse reactions. PACLitaxel 175 mg/m^2 x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m^2 x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours (use Non DEHP tubing with 0.22 micron or smaller in-line filter) CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 250 mL NS over 30 minutes				
acetaminophen 325 mg – 650 mg PO PRN for headache and rigors				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC:



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DATE:	To be given:	Cycle #:
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____.		
<input type="checkbox"/> Last Cycle. Return in _____ weeks.		
CBC & Diff, Platelets, Creatinine prior to each cycle		
If clinically indicated: <input type="checkbox"/> Total Bilirubin <input type="checkbox"/> AST		
<input type="checkbox"/> Consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: