



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: BRLAACDT (Page 1 of 2)

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 x 10⁹/L, Platelets greater than 90 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to AC treatment dexamethasone 8 mg or 12 mg (circle one) PO prior to AC treatment <input type="checkbox"/> aprepitant 125 mg PO pre-chemotherapy on Day 1 and 80 mg PO post-chemotherapy once daily on Days 2 and 3 <input type="checkbox"/> prochlorperazine 10 mg PO prn <input type="checkbox"/> metoclopramide 10 mg PO prn 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. <input type="checkbox"/> Other: _____				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY: (Note – continued over 2 pages) <input type="checkbox"/> CYCLE # _____ (Cycle 1-4) DOXOrubicin 60 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push cyclophosphamide 600 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour <p style="text-align: center;">*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8 ***</p>				
DOCTOR'S SIGNATURE:			UC SIGNATURE:	



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PROTOCOL CODE: BRLAACDT (Page 2 of 2)

DOCTOR'S ORDERS (Page 2 of 2)

DATE:

To be given:

Cycle #:

CHEMOTHERAPY: (Continued)

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

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

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

DOCEtaxel 100 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in NS 250 to 500 mL (non-DEHP bag) over 1 hour (Use non-DEHP tubing)

☐ **CYCLE # 6**

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

DOCEtaxel 100 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² 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 (HERCEPTIN) 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*)

DOCEtaxel 100 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² 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

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, AST, ALT, Alk Phos**

If clinically indicated:

☐ Tot. Prot ☐ Albumin ☐ Bilirubin ☐ GGT ☐ Alk Phos.

☐ AST ☐ LDH ☐ ALT ☐ Creatinine

☐ **Other tests:**

☐ **MUGA scan or Echo:** 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:

SIGNATURE:

UC: