



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: BRAJFECDT

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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 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 FEC treatment dexamethasone 8 mg or 12 mg (circle one) PO prior to FEC 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 <input type="checkbox"/> hydrocortisone 100 mg IV 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 1-3 epirubicin 100 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push fluorouracil 500 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push cyclophosphamide 500 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 OR <input type="checkbox"/> CYCLE # 4 (Cycle 1 of trastuzumab (HERCEPTIN) and DOCEtaxel) trastuzumab (HERCEPTIN) 8 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion. DOCEtaxel 100 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour. (Use non-DEHP tubing) | | | | |
| *** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 6 *** | | | | |
| DOCTOR'S SIGNATURE: | | | SIGNATURE: | |
| | | | UC: | |



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| | |
|---|---------------------|
| DOCTOR'S ORDERS (Page 2 of 2) | |
| DATE: | To be given: |
| Cycle #: | |
| <p>CHEMOTHERAPY: (Continued)</p> <p style="text-align: center;">*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLES 1 TO 4 ***</p> <p><input type="checkbox"/> CYCLE # 5</p> <p>trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour. Observe for 30 minutes post infusion.</p> <p>DOCEtaxel 100 mg/m² x BSA = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg</p> <p style="padding-left: 40px;">IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)</p> <p><input type="checkbox"/> Cycle # 6:</p> <p>trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over NS over 30 minutes. Observe for 30 minutes post infusion.</p> <p>DOCEtaxel 100 mg/m² x BSA = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg</p> <p style="padding-left: 40px;">IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)</p> <p>acetaminophen 325 mg to 650 mg PO PRN for headache and rigors</p> | |
| RETURN APPOINTMENT ORDERS | |
| <p><input type="checkbox"/> Return in three weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Last Cycle. Return in three weeks for Doctor and BRAJTR (to continue single agent trastuzumab)</p> | |
| <p>CBC & Diff, Platelets prior to each cycle</p> <p>Prior to Cycle 4: Bilirubin, AST, ALT, Alk Phos</p> <p>If clinically indicated:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos <input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> Creatinine </p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> MUGA scan or Echo: prior to Cycle 1 and 4 and then every <input type="checkbox"/> 3 months or <input type="checkbox"/> 4 months until completion of treatment</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p> | |
| DOCTOR'S SIGNATURE: | SIGNATURE: |
| | UC: |