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: BRAVTR

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 (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 250 mL NS over 1 hour 30 minutes. Observe for 1 hour post infusion*.

OR

☐ **Cycle 2**

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

☐ **Cycle 3 and Subsequent: (For patients who have just completed a trastuzumab-containing chemotherapy regimen)**

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes** every three weeks x

_____ Cycle(s). Observe for 30 minutes post-infusion*.

* Observation period not required after 3 treatments with no reaction

** 30 minute infusion time for Cycle 3 and all subsequent cycles, if no previous adverse reactions.

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

Proceed with treatment based on blood work from _____

DOCTOR'S SIGNATURE:	SIGNATURE: UC:

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: BRAVTR

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m^2**

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____.

☐ Return in _____ weeks for Doctor and Cycle(s) _____.

CBC & Diff, platelets prior to Cycle #2

☐ **CBC & Diff, platelets every 12 weeks**

If clinically indicated x _____weeks:

☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan** ☐ **CA15-3**

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

☐ **AST** ☐ **LDH** ☐ **ALT** ☐ **BUN** ☐ **Creatinine**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: