PROTOCOL CODE: BRAVPTRAT

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:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff, platelets** day of treatment
If ordered, may proceed with doses as written if within 24 hrs **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 90 x 10^9/L**
Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
45 Minutes Prior to PACLitaxel: **dexamethasone 20 mg** IV in NS 50 mL over 15 minutes
30 Minutes Prior to PACLitaxel: **diphenhydrAMINE 50 mg** IV and **ranitidine 50 mg** IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)
☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY:

☐ **CYCLE # 1**
DAY 1
PERTuzumab 840 mg IV in 250 mL NS over 1 hour. Observe for 1 hour post-infusion
DAY 2
trastuzumab (HERCEPTIN) 8 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes
Observe for 1 hour post infusion.
PACLItaxel 175 mg/m^2 OR **150 mg/m^2** (circle one) x BSA =_____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

OR

☐ **CYCLE # _____ (Cycle 2 to 8)**
PERTuzumab 420 mg IV in 250 mL NS. Administer cycle 2 over 1 hour. Observe for 30 minutes to 1 hour post infusion.
Cycle 3 onwards: Administer over 30 minutes. Observe for 30 minutes to 1 hour post infusion.*
trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes to 1 hour
Observe for 30 minutes post infusion*.
PACLItaxel 175 mg/m^2 OR **150 mg/m^2** (circle one) x BSA =_____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

OR

☐ **CYCLE #_____ (PERTuzumab and trastuzumab only)**
PERTuzumab 420 mg IV in 250 mL NS over 30 minutes.
trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes.
*Observation period not required after 3 treatments with no reaction.
acetaminophen 325 to **650 mg** PO PRN for headache and rigors

DOCTOR SIGNATURE:	UC SIGNATURE:

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RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle_____

☐ Last Cycle. Return in _____weeks.

Prior to cycles containing PACLitaxel (i.e., **cycles 1 to 9 only): CBC & Diff, Platelets**

Prior to **Cycle 4**: **Bilirubin, ALT, GGT, alk phos**

☐ **CBC & Diff, platelets**

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.**

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

☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Other tests:** ☐ **ECG**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: