Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: UBRAJTTW

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

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

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than 90 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

PREMEDICATIONS:

45 minutes prior to PACLitaxel: dexamethasone 10 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV and **ranitidine 50 mg** IV in 50 mL NS over 20 minutes

(Compatible up to 3 hours when mixed in bag)

☐ No pre-medication to PACLitaxel required (see protocol for guidelines)

☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE #1, Week 1, Day 1**

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

CYCLE #1, Week 1, Day 2

PACLitaxel 80 mg/m^2 OR _____ mg/m^2 (circle one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

☐ **CYCLE #1, Weeks 2 and 3**

PACLitaxel 80 mg/m^2 OR _____ mg/m^2 (circle one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 2 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

***** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 4*****

DOCTOR'S SIGNATURE:	SIGNATURE: UC:

DOCTOR'S ORDERS

DATE:

CHEMOTHERAPY: (Continued)

***** SEE PAGE 1 FOR CHEMOTHERAPY CYCLE 1 *****

☐ **CYCLE # 2**

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in NS 250 mL over NS over 1 hour once every 3 weeks. Observe for 30 minutes post infusion.

PACLitaxel 80 mg/m^2 OR _____ mg/m^2 (circle one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

☐ **CYCLE # 3 and 4**

trastuzumab (HERCEPTIN) 6 mg/kg x _____ kg =_____mg IV in NS 250 mL over NS over 30 minutes once every 3 weeks. Observe for 30 minutes post infusion (not required after 3 treatments with no reaction).

PACLitaxel 80 mg/m^2 OR _____ mg/m^2 (circle one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

acetaminophen 325 mg – 650 mg PO PRN for headache and rigors

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. (Book chemo room weekly x 12 weeks, then **switch to BRAJTR**).

☐ Last Cycle. Return in **three** weeks for Doctor and BRAJTR (to continue single agent trastuzumab).

CBC & Diff, Platelets prior to each weekly dose

If clinically indicated: ☐ **Total Bilirubin** ☐ **AST**

☐ **Other tests:** ☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: