BC CANCER
Provincial Health Services Authority

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: BRAVENH

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 96 hours **ANC greater than or equal to 1.0 x 10^9/L and Platelets greater than or equal to 75 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 _____.

dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment
☐ **Other:**

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

CHEMOTHERAPY: All lines to be primed with D5W

trastuzumab deruxtecan (ENHERTU) 5.4 mg/kg x _____kg =_____mg
☐ Dose Modification: _____ mg/kg x _____kg = _____ mg

IV in 100 mL D5W (use 0.2 micron in-line filter) over 1 h 30 min. Observe for 1 hour 30 minutes post infusion. If no infusion reaction observed in Cycle 1, may administer subsequent cycles over 30 minutes, observe for 30 minutes post-infusion. Observation period not required after 3 treatments with no reaction.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle____.
☐ Last Cycle. Return in _____weeks.

CBC & Diff, platelets, creatinine, total bilirubin, ALT prior to each cycle
If clinically indicated:
☐ **alkaline phosphatase** ☐ **CA 15-3** ☐ **sodium** ☐ **potassium** ☐ **magnesium**
☐ **calcium** ☐ **albumin** ☐ **phosphorous**
☐ **Echocardiogram** every 12 weeks **or** ☐ **MUGA scan** every 12 weeks
☐ **CT Chest** ☐ **serum HCG or** ☐ **urine HCG**
☐ **Other Tests**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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