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

Cycles 1 to 8: 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 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 in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 3 pages)

☐ **CYCLE # 1**

DAY 1

PERTuzumab 840 mg IV in 250 mL NS over 1 hour. Observe for 1 hour post-infusion

DAY 2

trastuzumab 8 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes

Observe for 1 hour post infusion.

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

PACLitaxel ☐ **175 mg/m^2** OR ☐ **150 mg/m^2** (select one) x BSA =_____ mg

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

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter.)

***** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 8*****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DOCTOR'S ORDERS

Date: **To be given:** **Cycle #:**

CHEMOTHERAPY: (Continued)

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

OR

☐ **CYCLE # 2**

PERTuzumab 420 mg IV in 250 mL NS over 1 hour. Observe for 30 minutes to 1 hour post infusion.

trastuzumab 6 mg/kg x _____ kg =_____mg IV in NS 250 mL over NS over 1 hour.

Observe for 30 minutes post infusion.

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

PACLitaxel ☐ **175 mg/m^2** OR ☐ **150 mg/m^2** (select one) x BSA =_____ mg

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

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter.)

OR

☐ **CYCLE # _____ (Cycle 3 to 8)**

PERTuzumab 420 mg IV in 250 mL NS over 30 minutes. Observe for 30 minutes to 1 hour post infusion.*

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes.

Observe for 30 minutes post infusion*.

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

PACLitaxel ☐ **175 mg/m^2** OR ☐ **150 mg/m^2** (select one) x BSA =_____ mg

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

IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter.)

*Observation period not required after 3 treatments with no reaction.

***** SEE PAGE 3 FOR CHEMOTHERAPY CYCLES 9 onwards*****

DOCTOR SIGNATURE:

SIGNATURE:

UC:

DOCTOR'S ORDERS

DATE: **To be given:** **Cycle #:**

CHEMOTHERAPY: (Continued)

*** SEE PAGES 1 and 2 FOR CHEMOTHERAPY CYCLES 1 to 8 ***

OR

☐ **CYCLE #_____ (PERTuzumab and trastuzumab only)** every ☐ **three** or ☐ **four** weeks (select one)

PERTuzumab 420 mg IV in 250 mL NS over 30 minutes.

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes.

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

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

RETURN APPOINTMENT ORDERS

☐ Return in **three** or **four** weeks (circle one) for Doctor and Cycle_____.

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

☐ 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 SIGNATURE:

SIGNATURE:

UC: