PROTOCOL CODE: UBRAVTTCAP

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 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 50 mL/min, bilirubin less than or equal to 1.5 x ULN, ALT less than or equal to 5 x ULN**

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

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **Other:**

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

TREATMENT:

☐ **CYCLE #1:**

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

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		

tucatinib* 300 mg PO BID on days 1 to 21 continuously

Dose modification if required:

☐ **tucatinib* 250 mg** PO BID on days 1 to 21 continuously

☐ **tucatinib* 200 mg** PO BID on days 1 to 21 continuously

☐ **tucatinib* 150 mg** PO BID on days 1 to 21 continuously

***** Dispense in original container

capecitabine 1000 mg/m^2 x BSA x (_____%) = _____mg PO BID x 14 days on days 1 to 14.

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

***** SEE PAGE 2 FOR TREATMENT CYCLE 2 ONWARDS*****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DOCTOR'S ORDERS

DATE:

TREATMENT: (Continued)

***** SEE PAGE 1 FOR TREATMENT CYCLE 1 *****

OR

☐ **CYCLE #2**

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		

tucatinib* 300 mg PO BID on days 1 to 21 continuously.

Dose modification if required:

- ☐ **tucatinib* 250 mg** PO BID on days 1 to 21 continuously
- ☐ **tucatinib* 200 mg** PO BID on days 1 to 21 continuously
- ☐ **tucatinib* 150 mg** PO BID on days 1 to 21 continuously

***** Dispense in original container

capecitabine 1000 mg/m^2 x BSA x (_____%) = _____mg PO BID x 14 days on days 1 to 14.

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

OR

☐ **CYCLE 3 and subsequent**

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

Observe for 30 minutes post infusion. Observation period not required after 3 treatments with no reaction.

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		

tucatinib* 300 mg PO BID on days 1 to 21 continuously.

Dose modification if required:

- ☐ **tucatinib* 250 mg** PO BID on days 1 to 21 continuously
- ☐ **tucatinib* 200 mg** PO BID on days 1 to 21 continuously
- ☐ **tucatinib* 150 mg** PO BID on days 1 to 21 continuously

***** Dispense in original container

capecitabine 1000 mg/m^2 x BSA x (_____%) = _____mg PO BID x 14 days on days 1 to 14.

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

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

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets, creatinine, bilirubin, ALT prior to each cycle

Cycle 1: weekly nursing assessment

☐ **INR Weekly** ☐ **INR prior to each cycle**

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT**
☐ **Alk Phos** ☐ **LDH** ☐ **BUN** ☐ **CA 15-3**

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

☐ **Weekly nursing assessment**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:
UC: