



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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: BRAJTR

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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: _____ To be given: _____ Cycle # of Trastuzumab: _____

Date of Previous Cycle: _____

Indicate the number of trastuzumab doses patient has received together with chemotherapy (not as single agent) to date: _____

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

TREATMENT:

- ☐ **Cycle 1 Only (NEW patients ONLY – Omit for patients continuing single-agent trastuzumab following a trastuzumab-containing chemotherapy regimen)**

trastuzumab 8 mg/kg x _____ kg = _____ mg IV in NS 250 mL 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		

OR

- ☐ **Cycle 2**

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in NS 250 mL 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		

- ☐ **Cycle 3 and subsequent (maximum 17 cycles total including previous adjuvant chemotherapy containing trastuzumab:**

trastuzumab 6 mg/kg x _____ kg = _____ mg IV in NS 250 mL over 30 minutes x _____ cycle(s). Observe for 30 minutes post-infusion (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		

acetaminophen 325 to 650 mg PO PRN for headache and rigors

Proceed with treatment based on blood work from _____

DOCTOR'S SIGNATURE:

**UC
SIGNATURE:**



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RETURN APPOINTMENT ORDERS

- ☐ Return in **three** weeks for Doctor and Cycle _____.
- ☐ Return in _____ weeks for Doctor and Cycle(s) _____.
- ☐ Last Cycle. Return in _____ weeks.

MUGA Scan or Echocardiogram every ☐ 3 months or ☐ 4 months from onset of trastuzumab and upon completion of treatment (17 cycles).

If clinically indicated x _____ weeks:

- ☐ **CBC & Diff, platelets** prior to next treatment
- ☐ **ECG** ☐ **Echocardiogram** ☐ **MUGA Scan**
- ☐ **CA15-3** ☐ **Bilirubin** ☐ **GGT**
- ☐ **Alk Phos** ☐ **ALT** ☐ **LDH** ☐ **Creatinine**
- ☐ **Other tests:**
- ☐ **Consults:**
- ☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

**UC
SIGNATURE:**