

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 <u>www.bccancer.bc.ca</u> and according to acceptable standards of care

## **PROTOCOL CODE: BRAJTTW**

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DOCTOR'S ORDERS	Htcm	Wtkg	BSAm²	
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 1.0 x 10 <sup>9</sup> /L, Platelets greater than 90 x 10 <sup>9</sup> /L				
Dose modification for: Hematology Other Toxicity				
Proceed with treatment based on blood work from				
PREMEDICATIONS:				
45 minutes prior to PACLitaxel: dexameth	asone 10 mg IV in 50 r	nL NS over 15 minu	tes	
30 minutes prior to PACLitaxel: diphenhy	-			
in NS 100 mL over 15 minutes (Y-site compa	tible)		-	
No pre-medication to PACLitaxel required	d (see protocol for guide	elines)		
Other:				
**Have Hypersensitivity Reaction Tray and Protocol Available**				
CHEMOTHERAPY: (Note – continued over 2 pages)				
CYCLE #1, Week 1, Day 1				
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 com	plete. Please print.)	Pharmacist Init	tial and Date	
trastuzumab				
CYCLE #1, Week 1, Day 2				
<b>PACLitaxel</b> $\square$ 80 mg/m <sup>2</sup> OR $\square$ mg/m <sup>2</sup> (select one) x BSA = mg				
Dose Modification:% = mg/m <sup>2</sup> x BSA = mg				
IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter)				
CYCLE #1, Weeks 2 and 3				
<b>PACLitaxel</b> $\square$ 80 mg/m <sup>2</sup> OR $\square$ mg/m <sup>2</sup> (select one) x BSA = mg				
Dose Modification: $\%$ = $mg/m^2 x BSA = mg$				
IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour once weekly x 2 weeks (use non-DEHP tubing with 0.2 micron				
in-line filter)				
*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 4***				
DOCTOR'S SIGNATURE:			UC	
DOCTOR 3 SIGNATURE:			SIGNATURE:	



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DOCTOR'S ORDERS				
DATE:				
CHEMOTHERAPY: (Continued)				
*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLE 1 ***				
<b>trastuzumab 6 mg/kg</b> x kg =mg IV in 250 mL NS over 1 hour once every 3 weeks. 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.)			
trastuzumab				
PACLitaxel 30 mg/m <sup>2</sup> OR mg/m <sup>2</sup> (select one) x BSA = mg Dose Modification:% = mg/m <sup>2</sup> x BSA = mg IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.2 micron in-line filter) CYCLE # 3 and 4 trastuzumab 6 mg/kg x kg = mg IV in 250 mL NS over 30 minutes once every 3 weeks. 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 pri	nt.)	Pharmacist Initial and Date	
trastuzumab	trastuzumab			
PACLitaxel [] 80 mg/m² OR [] mg/m² (select one) x BSA = mg         [] Dose Modification:% = mg/m² x BSA = mg         IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.2 micron in-line filter)         acetaminophen 325 mg – 650 mg PO PRN for headache and rigors				
DOCTOR'S SIGNATURE:		UC	UC	
		SIGNATURE:		



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DOCTOR'S ORDERS				
DATE:				
RETURN APPOINTMENT ORDERS				
Return in three weeks for Doctor and Cycle (Book chemo room weekly x 3 for cycles $1 - 4$ , then switch to BRAJTR).				
Last Cycle. Return in <u>three</u> weeks for Doctor and BRAJTR (to continue single agent trastuzumab).				
CBC & Diff, Platelets prior to each weekly dose				
If clinically indicated: 🗌 Total Bilirubin 🛛 🛛 ALT				
Other tests: ECG Echocardiogram MUGA Scan				
Consults:				
See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:	UC			
	SIGNATURE:			