PROTOCOL CODE: BRAVTCAP

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.**

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:

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes on Day 1

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		

capecitabine 1250 mg/m^2 or **1000 mg/m^2** (circle one) 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 – 650 mg PO PRN for headache and rigors

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets, Creatinine prior to each cycle

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

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT**

☐**Alk Phos** ☐**LDH** ☐**ALT** ☐ **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: