CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Perjeta®(PERTuzumab) 840 mg - Herceptin®(trastuzumab) 8 mg/kg - Abraxane®(NAB-PACLitaxel) 100 Regimen: Cycle 1 (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: PERT/Herceptin(trastuzumab)21 ABRAX100
Adult Chemotherapy - Medical Oncology
Metastatic Breast Cancer Therapy

CC1840 0055 06 2020

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY
Cycle_____ of _____ **Cycle Duration: 21 days**
Planned Administration Date: DD/MONTH/YYYY
Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

☐ Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

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Doctor's Order Sheet

Perjeta®(PERTuzumab) 840 mg - Herceptin®(trastuzumab) 8 mg/kg - Abraxane®(NAB-PACLitaxel) 100 Regimen: Cycle 1
(Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: PERT/Herceptin(trastuzumab)21 ABRAX100
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Metastatic Breast Cancer Therapy

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Perjeta® (PERTuzumab) 840 mg**

IV in 250 mL normal saline over 60 minutes on day 1

☐ **Herceptin® (trastuzumab) 8 mg/kg** X Weight (kg) **= _____ mg**

IV in 250 mL normal saline over 90 minutes on day 2

☐ **Abraxane® (NAB-PACLitaxel) 100 mg/m²** X BSA =_____**mg**

☐ Dose modification: **Abraxane® (NAB-PACLitaxel) 100 mg/m²** X BSA - _____% = _____**mg**

IV in Viaflex bag over 30 minutes on days 2 and 9

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____