



Doctor's Order Sheet
Kanjinti (trastuzumab) Maintenance
Regimen:
**Kanjinti® (trastuzumab)
6 mg/kg**

Name: _____
HCN: _____
Date of Birth: _____

ARIA Protocol Name: Kanjinti (trastuzumab)21 Maintenance
Adult Chemotherapy - Medical Oncology
Metastatic Breast Cancer Therapy



CC3030 0114 07 2020

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____

Cycle Duration: 21 days

Date of previous cycle: DD/MONTH/YYYY

ROUTINE BLOODWORK NOT REQUIRED:

- CBC as clinically indicated
- LFTs and Bilirubin assessed, as clinically indicated

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

Kanjinti® (trastuzumab) 6 mg/kg X Weight (kg) = _____ mg

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

Cycle 3 and beyond can be administered over 30 minutes if no previous adverse reaction

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.