CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

HTCyclo Kanjinti (Post Cycle 1)

Kanjinti™ (trastuzumab) 6 mg/kg - cyclophosphamide 600 - DOCEtaxel 75 (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: HTCyclo Kanjinti (trastuzumab)

Adult Chemotherapy - Medical Oncology

Adjuvant Breast Cancer Therapy

CC2250 0096 01 2021

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** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY)

☐ **dexamethasone 8 mg PO** bid for 3 days starting the day before DOCEtaxel

Patient must receive a minimum of three doses prior to receiving treatment.

☐ Other: _____

PREMEDICATIONS (FOR HOSPITAL PHARMACY)

☐ **ondansetron 16 mg PO** on day 1

☐ 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

HTCyclo Kanjinti (Post Cycle 1)

Kanjinti™ (trastuzumab) 6 mg/kg - cyclophosphamide 600 - DOCEtaxel 75 (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: HTCyclo Kanjinti (trastuzumab)
Adult Chemotherapy - Medical Oncology
Adjuvant Breast Cancer Therapy

CC2250 0096 01 2021

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

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **normal saline 1000 mL IV** over 60 minutes pre-cyclophosphamide on day 1

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

Cycles 3 - 18 can be administered over 30 minutes if no adverse reaction

☐ **cyclophosphamide 600 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **cyclophosphamide 600 mg/m²** X BSA - _____% = _____ **mg**

IV in 100 to 250 mL normal saline over 60 minutes on day 1, **Cycles 2 to 4**

☐ **DOCEtaxel 75 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **DOCEtaxel 75 mg/m²** X BSA - _____% = _____ **mg**

IV in 250 to 500 mL normal saline PVC free bag over 60 minutes on day 1, **Cycles 2 to 4**

POST-CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **filgrastim** (Brand: _____) _____ **mcg subcutaneous** daily for 7 days starting 24-48 hours post chemotherapy

☐ **pegfilgrastim** (Brand:_____) **6 mg subcutaneous** for one dose 24-48 hours post chemotherapy

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: _____