

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor's Order Sheet

**Perjeta®(PERTuzumab) 840 mg**

**- Kanjinti®(trastuzumab) 8 mg/kg**

**- Abraxane®(nab-PACLitaxel) 100** Regimen: Cycle 1 (Part I)

**ARIA Protocol Name: PERT/Kanjinti(trastuzumab)21 ABRAX100**

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy



CC3940 0205 06 2022

**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

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to** 1.5 X 10<sup>9</sup>/L and platelets **greater than or equal to** 100 X 10<sup>9</sup>/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.

Doctor's Order Sheet

**Perjeta® (PERTuzumab) 840 mg**  
**- Kanjinti® (trastuzumab) 8 mg/kg**  
**- Abraxane® (nab-PACLitaxel) 100**

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Regimen: Cycle 1 (Part II)

**ARIA Protocol Name:** PERT/Kanjinti(trastuzumab)21 ABRAX100

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy



CC3940 0205 06 2022

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

**Kanjinti® (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/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**

Dose modification: **Abraxane® (nab-PACLitaxel) 100 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**

**IV** in empty 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: \_\_\_\_\_

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