CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

Kanjinti®(trastuzumab) 8 mg/kg - tucatinib 300 mg - capecitabine 1000

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Kanjinti Tucatinib Capecitabine

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy

CC5230 0333 05 2023

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 10^9/L and platelets **greater than or equal to** 75 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: _____

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Name:

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Cancer Care Program Doctor's Order Sheet

Kanjinti®(trastuzumab) 8 mg/kg - tucatinib 300 mg - capecitabine 1000

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Kanjinti Tucatinib Capecitabine

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy

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

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **capecitabine 1000 mg/m²** X BSA = _____**mg**

☐ Dose modification: **capecitabine 1000 mg/m²** X BSA - _____% = _____**mg**

PO BID with food on day 1 to day 14

☐ **tucatinib 300 mg**

☐ Dose modification: **tucatinib 250 mg**

☐ Dose modification: **tucatinib 200 mg**

☐ Dose modification: **tucatinib 150 mg**

PO BID continuously

Mitte: 30 days

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

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

IV in 250 mL normal saline over 90 minutes on day 1

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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.