

Name: _____

HCN: _____

Date of Birth: _____

Doctor's Order Sheet

**Kanjinti® (trastuzumab) 6 mg/kg -
tucatinib 300 mg - capecitabine 1000**

Regimen: Post Cycle 1 (Part I)

ARIA Protocol Name: Kanjinti Tucatinib Capecitabine

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy



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Allergies:

No Known

Date: DD/MONTH/YYYY
Cycle _____ of _____

Planned Administration Date: DD/MONTH/YYYY

Cycle Duration: 21 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, 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.

Name: _____

HCN: _____

Date of Birth: _____

**Kanjinti®(trastuzumab) 6 mg/kg -
tucatinib 300 mg - capecitabine 1000**

Regimen: Post 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) 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

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Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

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