

CyBorD Regimen:

**cyclophosphamide 300 - bortezomib 1.5 -
dexamethasone 40 mg Cycle 1 (Part I)**

ARIA Protocol Name: CyBor D 1.5

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4150 0226 08 2022

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____

Cycle Duration: 28 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1 \times 10^9/L$ and platelets **greater than or equal to** $80 \times 10^9/L$, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

allopurinol 300 mg PO on day 1

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

allopurinol 300 mg PO once daily on days 2 to 5

metoclopramide 10-20 mg PO every 4 hours as needed

acyclovir 800 mg PO once daily until one month post completion of bortezomib treatment

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
CyBorD Regimen:

Name: _____

HCN: _____

Date of Birth: _____

**cyclophosphamide 300 - bortezomib 1.5 -
dexamethasone 40 mg Cycle 1 (Part II)**

ARIA Protocol Name: CyBor D 1.5

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

dexamethasone 40 mg

Dose modification: **dexamethasone 40 mg** - _____ % = _____ mg

PO pre bortezomib on day 1

cyclophosphamide 300 mg/ m² X BSA = _____ mg

Dose modification: **cyclophosphamide 300 mg/m² X BSA** - _____ % = _____ mg

PO pre bortezomib on day 1

bortezomib 1.5 mg/m² X BSA = _____ mg

Dose modification: **bortezomib 1.5 mg/m² X BSA** - _____ % = _____ mg

SC on day 1, 8, 15 and 22

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 40 mg

Dose modification: **dexamethasone 40 mg** - _____ % = _____ mg

PO pre bortezomib on day 8, 15 and 22

cyclophosphamide 300 mg/ m² X BSA = _____ mg

Dose modification: **cyclophosphamide 300 mg/m² X BSA** - _____ % = _____ mg

PO pre bortezomib on day 8, 15 and 22

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist

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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