

**bortezomib 1.3** Regimen

**ARIA Protocol Name:** Bortezomib (maint) 1.3 q14d

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4970 0307 04 2023

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

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**  $0.5 \times 10^9/L$  and platelets **greater than or equal to**  $30 \times 10^9/L$ , otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Neurotoxicity assessment complete

**PREMEDICATIONS:** None recommended

Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**bortezomib 1.3 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**

Dose modification: **bortezomib 1.3 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**

**SC** on day 1 and 15

**HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):**

**metoclopramide 10-20 mg PO** every four 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.