

Doctor's Order Sheet
**carfilzomib 20/70 -
dexamethasone 40 mg**

Regimen: Cycle 1 (Part I)
ARIA Protocol Name: Carfilzomib (Weekly) Dex
Adult Chemotherapy - Hematology Oncology
Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC4910 0301 03 2023

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 $10 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- allopurinol 300 mg PO on day 1
 Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

- sodium chloride 0.9% 250 mL IV over 30 minutes pre-carfilzomib on day 1, 8 and 15
 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
 acetylsalicylic acid 81 mg PO once daily
 acyclovir 800 mg PO once daily until 1 month post completion of carfilzomib 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
**carfilzomib 20/70 -
dexamethasone 40 mg**

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Carfilzomib (Weekly) Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



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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 on day 1 (30 minutes to 4 hours pre-carfilzomib)

carfilzomib 20 mg/m² X BSA = _____ mg (cap BSA at 2.2 m²)

Dose modification: **carfilzomib 20 mg/m² X BSA** - _____ % = _____ mg (cap BSA at 2.2 m²)

IV in 100 mL D5W over 30 minutes on day 1. Observe patient for one hour following each carfilzomib infusion.

carfilzomib 70 mg/m² X BSA = _____ mg (cap BSA at 2.2 m²)

Dose modification: **carfilzomib 70 mg/m² X BSA** - _____ % = _____ mg (cap BSA at 2.2 m²)

IV in 100 mL D5W over 30 minutes on day 8 and 15. Observe patient for one hour following each carfilzomib infusion.

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 40 mg

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

PO on day 8, 15 and 22 (30 minutes to 4 hours pre-carfilzomib on carfilzomib days)

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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