

Doctor's Order Sheet

**carfilzomib 70 -
dexamethasone 40 mg**

Regimen: Cycles 2 + (Part I)

ARIA Protocol Name: Carfilzomib (Weekly) Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4920 0302 03 2023

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

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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 70 -
dexamethasone 40 mg**

Regimen: Cycles 2 + (Part II)

ARIA Protocol Name: Carfilzomib (Weekly) Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

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 1, 8 and 15

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 40 mg

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

PO on day 1, 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

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Authorized Prescriber's Signature: _____ ID #: _____

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

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