CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

bortezomib 1.3 - dexamethasone 40 mg - selinexor 100 mg Regimen: (Part I)

ARIA Protocol Name: Selinexor Bortez Dex - Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4170 0228 11 2022

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 35 days**

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ Other: _____

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **ondansetron 8 mg PO** pre selinexor on day 1, 8, 15, 22 and 29

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **metoclopramide 10-20 mg PO** every 4 hours as needed

☐ **acyclovir 800 mg PO** once daily until 30 days 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

bortezomib 1.3 - dexamethasone 40 mg - selinexor 100 mg Regimen: (Part II)

ARIA Protocol Name: Selinexor Bortez Dex - Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **bortezomib 1.3 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **bortezomib 1.3 mg/m²** X BSA - _____% =_____ **mg**

SC on day 1, 8, 15 and 22

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg**

☐ Dose modification: **dexamethasone 20 mg**

PO pre selinexor on day 1, 8, 15, 22 and 29

☐ **selinexor 100 mg**

☐ Dose modification: **selinexor 80 mg**

☐ Dose modification: **selinexor 60 mg**

☐ Dose modification: **selinexor 40 mg**

PO on day 1, 8, 15, 22 and 29

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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