CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

carfilzomib 20/70 - cyclophosphamide 300 - dexamethasone 40 mg

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Carfilzomib Cyclo Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4090 0220 06 2022

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 X 10^9/L and platelets **greater than or equal to** 80 X 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 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: _____

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CANCERCare
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Cancer Care Program

Doctor's Order Sheet

carfilzomib 20/70 - cyclophosphamide 300 - dexamethasone 40 mg

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Carfilzomib Cyclo Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4090 0220 06 2022

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 m^2)

☐ Dose modification: **carfilzomib 20 mg/m²** X BSA - _____% =_____ **mg** (cap BSA at 2.2 m^2)

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 m^2)

☐ Dose modification: **carfilzomib 70 mg/m²** X BSA - _____% =_____ **mg** (cap BSA at 2.2 m^2)

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

☐ **cyclophosphamide 300 mg/ m²** X BSA **=** _____ **mg**

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

PO on day 1

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)

☐ **cyclophosphamide 300 mg/ m²** X BSA **=** _____ **mg**

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

PO on day 8 and 15

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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