

**carfilzomib 70 -  
cyclophosphamide 300 -  
dexamethasone 40 mg**

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



CC4100 0221 06 2022

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**  $1 \times 10^9/L$  and platelets **greater than or equal to**  $80 \times 10^9/L$ , otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

**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 -  
cyclophosphamide 300 -  
dexamethasone 40 mg**

Regimen: Post Cycle 1 (Part II)

ARIA Protocol Name: Carfilzomib Cyclo 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):**

- carfilzomib 70 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg** (cap BSA at 2.2 m<sup>2</sup>)
  - Dose modification: **carfilzomib 70 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg** (cap BSA at 2.2 m<sup>2</sup>)
- 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)
- cyclophosphamide 300 mg/ m<sup>2</sup> X BSA = \_\_\_\_\_ mg**
  - Dose modification: **cyclophosphamide 300 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**
- PO** on day 1, 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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