

**carfilzomib 20/27 -  
dexamethasone 40 mg -  
lenalidomide 25 mg**

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



CC4130 0224 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**  $30 \times 10^9/L$ , 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, 2, 8, 9, 15 and 16  
 Other: \_\_\_\_\_

**HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):**

- allopurinol 300 mg PO once daily on days 2 to 5  
 acetylsalicylic acid 81 mg PO once daily  
 acyclovir 800 mg PO once daily until 3 months 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 20/27 -  
dexamethasone 40 mg -  
lenalidomide 25 mg**

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Carfilzomib DEXA LENA

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC4130 0224 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/m<sup>2</sup> X BSA = \_\_\_\_\_ mg** (cap BSA at 2.2 m<sup>2</sup>)

Dose modification: **carfilzomib 20 mg/m<sup>2</sup> X BSA** - \_\_\_\_\_ % = \_\_\_\_\_ mg (cap BSA at 2.2 m<sup>2</sup>)

**IV** in 100 mL D5W over 10 minutes on day 1 and 2. Observe patient for one hour following each carfilzomib infusion.

**carfilzomib 27 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg** (cap BSA at 2.2 m<sup>2</sup>)

Dose modification: **carfilzomib 27 mg/m<sup>2</sup> X BSA** - \_\_\_\_\_ % = \_\_\_\_\_ mg (cap BSA at 2.2 m<sup>2</sup>)

**IV** in 100 mL D5W over 10 minutes on day 8, 9, 15 and 16. 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)

**lenalidomide 25 mg**

Dose modification: **lenalidomide 25 mg** - \_\_\_\_\_ % = \_\_\_\_\_ mg

**PO** once daily on days 1 to 21

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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