CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

carfilzomib 27 - dexamethasone 40 mg - lenalidomide 25 mg

Regimen: Cycles 13-18 (Part I)

ARIA Protocol Name: Carfilzomib Dexa Lena

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4120 0223 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 X 10^9/L and platelets **greater than or equal to** 30 X 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):

☐**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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

carfilzomib 27 - dexamethasone 40 mg - lenalidomide 25 mg

Regimen: Cycles 13-18 (Part II)

ARIA Protocol Name: Carfilzomib Dexa Lena

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4120 0223 06 2022

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **carfilzomib 27 mg/m²** X BSA **=** _____ **mg** (cap BSA at 2.2 m^2)

☐ Dose modification: **carfilzomib 27 mg/m²** X BSA - _____% =_____ **mg** (cap BSA at 2.2 m2)

IV in 100 mL D5W over 10 minutes on day 1, 2, 15 and 16

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)

☐ **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: _____