

CyBorP Pred & Cyclo q2days
Regimen:

cyclophosphamide 50 mg - bortezomib

1.3 - prednisone 100 mg Cycle 2 (Part I)

ARIA Protocol Name: CyBorP Pred & Cyclo q2days

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC6490 0459 02 2024

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: _____

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** 0.5 X 10⁹/L and platelets **greater than or equal to** 50 X 10⁹/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed
- Neurotoxicity assessment completed

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

metoclopramide 10-20 mg PO every 4 to 6 hours as needed

acyclovir 800 mg PO once daily until one month 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: _____

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Doctor's Order Sheet

CyBorP Pred & Cyclo q2days Regimen:

**cyclophosphamide 50 mg - bortezomib 1.3
- prednisone 100 mg Cycle 2 (Part II)**

ARIA Protocol Name: CyBorP Pred & Cyclo q2days

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: _____

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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):

cyclophosphamide 50 mg

Dose modification: **cyclophosphamide 50 mg - _____ % = _____ mg**

PO every second day for 35 days (alternating with prednisone) starting on day 2

prednisone 100 mg

Dose modification: **prednisone 100 mg - _____ % = _____ mg**

PO every second day for 33 days (alternating with cyclophosphamide) starting on day 3

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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