

**isatuximab 10 mg/kg -
carfilzomib 20/70 -
dexamethasone 40/20 mg**

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

Name: _____

HCN: _____

Date of Birth: _____



CC5180 0328 05 2023

Allergies:		<input type="checkbox"/> No Known
Date: <u>DD/MONTH/YYYY</u>	Planned Administration Date: <u>DD/MONTH/YYYY</u>	
Cycle <u> </u> of <u> </u>	Cycle Duration: 28 days	Date of previous cycle: <u>DD/MONTH/YYYY</u>
MAY PROCEED WITH DOSES AS WRITTEN IF:		
<ul style="list-style-type: none"> • 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. 		
PREMEDICATIONS (FOR HOSPITAL PHARMACY):		
<input type="checkbox"/> allopurinol 300 mg PO on day 1		
<input type="checkbox"/> 15-60 minutes prior to isatuximab: dexamethasone 40 mg IV in 50 mL normal saline over 15 minutes on day 1, 8, 15 and 22		
<input type="checkbox"/> Dose modification: dexamethasone 20 mg IV in 50 mL normal saline over 15 minutes on day 1, 8, 15 and 22		
<input type="checkbox"/> 30 minutes prior to isatuximab: montelukast 10 mg PO on day 1, 8, 15 and 22		
<input type="checkbox"/> 30 minutes prior to isatuximab: acetaminophen 650 mg PO on day 1, 8, 15 and 22		
<input type="checkbox"/> 30 minutes prior to isatuximab: diphenhydrAMINE 50 mg IV in 50 mL normal saline over 15 minutes on day 1, 8, 15 and 22		
<input type="checkbox"/> 30 minutes prior to isatuximab: ranitidine 150 mg PO on day 1, 8, 15 and 22		
HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):		
<input type="checkbox"/> Other: _____		
HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):		
<input type="checkbox"/> allopurinol 300 mg PO once daily on days 2 to 5		
<input type="checkbox"/> metoclopramide 10-20 mg PO every 4 to 6 hours as needed		
<input type="checkbox"/> acetylsalicylic acid 81 mg PO once daily continuously		
<input type="checkbox"/> acyclovir 800 mg PO once daily until 30 days post completion of treatment		
<input type="checkbox"/> 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

isatuximab 10 mg/kg
carfilzomib 20/70 -
dexamethasone 20/40 mg

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Isatuximab Carfilzomib 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):

isatuximab 10 mg/kg X weight (kg) = _____ mg

Dose modification: **isatuximab 10 mg/kg** X weight (kg) - _____ % = _____ mg

IV in 250 mL normal saline on day 1, 8, 15 and 22

First infusion: Observe patient for 30 minutes after infusion.

First Infusion: Initial Rate: 25 mL/hour for 60 minutes, if no reaction increase by 25 mL/hour every 30 minutes up to 150 mL/hour.

Second Infusion: Initial Rate: 50 mL/hour for 30 minutes, if no reaction increase by 50 mL/hour for 30 minutes, then increase by 100 mL/hour up to 200 mL/hour.

Subsequent Infusions: Administer over 30 minutes

carfilzomib 20 mg/m² X BSA = _____ mg (cap BSA at 2.2 m²)

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

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 m²)

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

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

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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