CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

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

Regimen: Cycles 2+ (Part I)

ARIA Protocol Name: Isatuximab Carfilzomib Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC5190 0329 05 2023

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** 0.5 X 10^9/L and platelets **greater than or equal to** 50 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **15-60 minutes prior to isatuximab: dexamethasone 40 mg IV** in 50 mL normal saline over 15 minutes on day 1 and 15

☐ Dose modification: **dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1 and 15

☐ **30 minutes to 4 hours prior to carfilzomib: dexamethasone 40 mg IV** in 50 mL normal saline over 15 minutes on day 8

☐ Dose modification: **dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 8

☐ **30 minutes prior to isatuximab: acetaminophen 650 mg PO** on day 1 and 15

☐ **30 minutes prior to isatuximab: diphenhydrAMINE 50 mg PO** on day 1 and 15

☐ **30 minutes prior to isatuximab: ranitidine 150 mg PO** on day 1 and 15

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ 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

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

Regimen: Cycles 2+ (Part II)

ARIA Protocol Name: Isatuximab Carfilzomib Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC5190 0329 05 2023

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

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ **acetylsalicylic acid 81 mg PO** once daily continuously

☐**acyclovir 800 mg PO** once daily until 30 days post completion of treatment

☐ Other: _____

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 over 30 minutes on day 1 and 15

☐ **carfilzomib 70 mg/m^2** X BSA **=** _____ **mg** (cap BSA at 2.2 m^2)

☐ Dose modification: **carfilzomib 70 mg/m^2** X BSA - _____% =_____ **mg** (cap BSA at 2.2 m^2)

IV in 100 mL D5W over 30 minutes on day 1, 8 and 15

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg**

☐ Dose modification: **dexamethasone 20 mg**

PO in the morning on day 22

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: _____