CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Doctor's Order Sheet

bortezomib 1.3 - dexamethasone 40 mg - selinexor 100 mg Regimen: (Part I)

ARIA Protocol Name: Selinexor Bortezomib IV Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC8000 0620 12 2025

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** 75 X 10^9/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **netupitant-palonosetron 300 mg-0.5 mg PO** pre selinexor on day 1, 8, 15 and 22

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **sodium chloride 0.9% 500 mL IV** pre-bortezomib over 60 minutes on day 1, 8 and 15

☐ **sodium chloride 0.9% 500 mL IV** post-bortezomib over 60 minutes on day 1, 8 and 15

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ **valacyclovir 500 mg PO** twice daily until 30 days 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

CANCERCare
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Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

bortezomib 1.3 - dexamethasone 40 mg - selinexor 100 mg Regimen: (Part II)

ARIA Protocol Name: Selinexor Bortezomib IV Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC8000 0620 12 2025

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **bortezomib 1.3 mg/m^2** X BSA **=** _____ **mg**

☐ Dose modification: **bortezomib 1.3 mg/m^2** X BSA - _____% =_____ **mg**

IV push on day 1, 8 and 15

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg**

☐ Dose modification: **dexamethasone 20 mg**

PO pre selinexor on day 1, 8, 15 and 22

☐ **selinexor 100 mg PO** on day 1, 8, 15 and 22

☐ Dose modification: **selinexor 80 mg PO** on day 1, 8, 15 and 22

☐ Dose modification: **selinexor 60 mg PO** on day 1, 8, 15 and 22

☐ Dose modification: **selinexor 40 mg PO** on day 1, 8, 15 and 22

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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