PROTOCOL CODE: MYBORPRE

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

Proceed with treatment for all medications for entire cycle as written, if within 96 hours of Day 1: **ANC greater than or equal to 0.5 x 10^9/L, platelets greater than or equal to 50 x 10^9/L, total bilirubin less than or equal to 1.5 x upper limit of normal, and creatinine clearance as per protocol**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity :** _____

Proceed with treatment based on blood work from _____

TREATMENT:

- A referral to the Leukemia/BMT Program of BC must be made at the start of the first cycle or shortly after for planning purposes.
- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

bortezomib ☐**1.5 mg/m^2** or ☐**1.3 mg /m^2** or ☐**1 mg/m^2** or ☐**0.7 mg/m^2** or ☐**0.5 mg/m^2** (select one) x BSA =____mg subcutaneous injection on Days 1, 8, 15 and 22

STEROID (select one)*

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** PO in morning on Days _____ *(write in)* of each cycle

☐ **dexamethasone** _____ **mg** PO in morning on Days _____ *(write in)* of each cycle

☐ **predniSONE** _____ **mg** PO in morning on Days _____ *(write in)* of each cycle

☐ **No Steroid**

* Refer to Protocol for suggested dosing options

NB: Bortezomib twice weekly dosing option available (see protocol). Orders should be handwritten on a separate order.

OPTIONAL CYCLOPHOSPHAMIDE:

☐ **cyclophosphamide 500 mg** PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles.

OR

☐ **cyclophosphamide** _____ **mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for _____ doses. Dispense ____ cycles

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

Date:	
RETURN APPOINTMENT ORDERS	
Return in **four** weeks for Doctor and Cycle _____. Book chemo on Days 1, 8, 15, 22 ☐ Last Cycle. Return in _____ week(s).	
Prior to each cycle: CBC & Diff, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis and serum free light chain levels ☐ **Urine protein electrophoresis** prior to each cycle ☐ **Immunoglobulin panel (IgA, IgG, IgM)** prior to each cycle ☐ **Beta-2 microglobulin** prior to each cycle ☐ **CBC & Diff** Days 8, 15, 22 ☐ **Creatinine, sodium, potassium** Days 8, 15, 22 ☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22 ☐ **Random glucose** Days 8, 15, 22 ☐ **Calcium, albumin** Days 8, 15, 22 ☐ **HBV viral load** prior to next cycle ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**