

**PROTOCOL CODE: MYBSD** Page 1 of 2

<b>DOCTOR'S ORDERS</b>			Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form			
DATE:	To be given:	Cycle #:	
Date of Previous Cycle:			
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment Proceed with treatment for all medications for entire cycle as written, if within 96 hours of Day 1: <b>ANC greater than or equal to <math>0.5 \times 10^9/L</math>, platelets greater than or equal to <math>50 \times 10^9/L</math>, total bilirubin less than or equal to 1.5 x upper limit of normal, and creatinine clearance as per protocol</b>  Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> : _____ <b>Proceed with treatment based on blood work from</b> _____			
<b>STEROID (select one)*</b> <input type="checkbox"/> <b>dexamethasone 20 mg</b> PO in morning on Days 1, 2, 8, 9, 15, 16, 22, 23 of each cycle <input type="checkbox"/> <b>dexamethasone</b> _____ mg PO in morning on Days _____ (write in) of each cycle <input type="checkbox"/> <b>predniSONE</b> _____ mg PO in morning on Days _____ (write in) of each cycle <input type="checkbox"/> <b>No Steroid</b> <b>*Refer to Protocol for suggested dosing options</b>			
<b>SELINEXOR PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>dexamethasone</b> as ordered in steroid section prior to selinexor antiemetics per protocol <input type="checkbox"/> Other: _____			
<b>selinexor 100 mg</b> PO on Days 1, 8, 15, 22 of each cycle Dose modification (select one): <input type="checkbox"/> <b>selinexor</b> _____ mg PO on Days 1, 8, 15, 22 of each cycle <input type="checkbox"/> <b>selinexor 60 mg</b> PO on Days 1, 4, 8, 11, 15, 18, 22, 25 of each cycle			
• Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily <b>bortezomib</b> <input type="checkbox"/> <b>1.3 mg/m<sup>2</sup></b> or <input type="checkbox"/> <b>1 mg/m<sup>2</sup></b> or <input type="checkbox"/> <b>0.7 mg/m<sup>2</sup></b> or <input type="checkbox"/> <b>0.5 mg/m<sup>2</sup></b> (select one) x BSA = _____ mg SC injection on Days 1, 8 and 15			
<b>OPTIONAL CYCLOPHOSPHAMIDE:</b> <input type="checkbox"/> <b>cyclophosphamide 500 mg</b> PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense _____ cycles. OR <input type="checkbox"/> <b>cyclophosphamide</b> _____ mg PO once weekly in the morning on Days _____ Dispense _____ cycles. OR <input type="checkbox"/> <b>cyclophosphamide 50 mg</b> PO once in the morning every 2 days for _____ doses. Dispense _____ cycles			
<b>DOCTOR'S SIGNATURE:</b>			<b>SIGNATURE:</b>  <b>UC:</b>

<b>Date:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
Return in <b>four</b> weeks for Doctor and Cycle _____. Book chemo on Days 1, 8 and 15. <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<b>CBC &amp; Diff, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis <u>and</u> serum free light chain levels</b> every 4 weeks  <b>CBC &amp; Diff, creatinine, sodium, potassium, magnesium, calcium</b> Days 8, 15, 22 of Cycle 1  During cycle 1: weekly telephone nursing assessment <input type="checkbox"/> Cycle 2 onward: every _____ weekly telephone nursing assessment for _____ weeks  <input type="checkbox"/> Urine protein electrophoresis every 4 weeks <input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks <input type="checkbox"/> Beta-2 microglobulin every 4 weeks <input type="checkbox"/> CBC & Diff Days 8, 15, 22 (Cycles 2 and onward) <input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22 (Cycles 2 and onward) <input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22 <input type="checkbox"/> Random glucose Days 8, 15, 22 <input type="checkbox"/> Calcium, albumin Days 8, 15, 22 <input type="checkbox"/> HBV viral load prior to next cycle <input type="checkbox"/> phosphate <input type="checkbox"/> urea <input type="checkbox"/> magnesium <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>