



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: MYCARDEX

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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: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment		
Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: ANC greater than or equal to 0.5 x 10⁹/L, platelets greater than or equal to 50 x 10⁹/L and creatinine clearance as per protocol		
Dose modification for: <input type="checkbox"/> Hematology: _____ <input type="checkbox"/> Other Toxicity: _____		
Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.		
OPTIONAL: If dexamethasone not given as part of the treatment regimen, and concerns regarding infusion reactions, 30 minutes prior to carfilzomib:		
<input type="checkbox"/> dexamethasone 4 mg PO <u>OR</u> <input type="checkbox"/> dexamethasone 4 mg IV in NS 50 mL over 15 minutes (select one)		
<input type="checkbox"/> ondansetron 8 mg PO prior to carfilzomib		
<input type="checkbox"/> Other: _____		
PREHYDRATION:		
Cycle 1:		
Pre-hydration: 250 mL NS IV over 30 minutes		
Cycle 2 onward (optional- see protocol):		
<input type="checkbox"/> 250 mL NS IV over 30 minutes		
TREATMENT:		
STEROID (select one)*		
<input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO once weekly, in the morning, on Days 1, 8, 15 and 22 of each cycle		
<input type="checkbox"/> dexamethasone _____ mg PO once weekly, in the morning on Days _____ (write in) of each cycle		
<input type="checkbox"/> predniSONE _____ mg PO once weekly, in the morning on Days _____ (write in) of each cycle		
<input type="checkbox"/> No Steroid		
*Refer to Protocol for suggested dosing options		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC:

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DOCTOR'S ORDERS

DATE:

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT (continued):

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

CARFILZOMIB

☐ **CYCLE 1:**

carfilzomib 20 mg/m² x BSA[‡] = _____ mg IV in 100 mL D5W over 30 minutes on Day 1

carfilzomib 70 mg/m² x BSA[‡] = _____ mg IV in 100 mL D5W over 30 minutes on Days 8 and 15

[‡] (cap BSA at 2.2)

Vital signs prior to EACH carfilzomib infusion

For Cycle 1 only, observe patient for 30 minutes following each carfilzomib infusion

☐ **CYCLE 2 onward:**

carfilzomib 70 mg/m² x BSA[‡] = _____ mg

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

[‡] (cap BSA at 2.2)

Vital signs prior to EACH carfilzomib infusion

DOSE MODIFICATION IF REQUIRED ON DAYS 8 AND/OR 15

carfilzomib 70 mg/m² x BSA[‡] = _____ mg

☐ Dose Modification: _____ mg/m² x BSA[‡] = _____ mg

IV in 100 mL D5W over 30 minutes on Days _____

POST HYDRATION (Optional- see protocol. May be given during carfilzomib observation):

☐ 250 mL NS IV over 30 minutes after carfilzomib

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:



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