



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: MYCARLD

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Patient RevAid # _____

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

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

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

Date of Previous Cycle:

Risk Category: **Female of Childbearing Potential (FCBP) Rx valid 7 days**

Risk Category: **Male or Female of non -Childbearing Potential (NCBP)**

Delay treatment _____ week(s)

CBC & Diff, Platelets day of treatment

- May proceed with carfilzomib Day 1 doses as written, if within 96 hours **ANC greater than or equal to 0.5 x 10⁹/L, Platelets greater than or equal to 10 x 10⁹/L, CrCl as per protocol**
- May proceed with carfilzomib Day 8 and 15 doses as written (if **Day 8 labs ordered**) if within 48 hours **ANC greater than or equal to 0.5 x 10⁹/L, Platelets greater than or equal to 10 x 10⁹/L, CrCl as per protocol**
- May proceed with lenalidomide doses as written, if within 96 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 30 x 10⁹/L, eGFR as per protocol**

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

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

If dexamethasone not given as part of the treatment regimen, 30 minutes prior to carfilzomib if using dexamethasone:

dexamethasone 4 mg PO OR **dexamethasone 4 mg IV** in NS 50 mL over 15 minutes (select one)

Other:

PREHYDRATION:

Cycle 1:

Pre-hydration: 250 mL NS IV over 30 minutes

Cycle 2 onward (optional):

250 mL NS IV over 30 minutes

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DOCTOR'S ORDERS	
DATE: _____	
<p>CHEMOTHERAPY: LENALIDOMIDE One cycle = 28 days</p> <p><input type="checkbox"/> lenalidomide* _____mg PO daily, in the evening, on Days 1 to 21 and off for 7 days</p> <p><input type="checkbox"/> lenalidomide* _____ mg PO _____ (*available as 25 mg, 20mg, 15 mg, 10 mg, 5 mg and 2.5 mg capsules)</p> <p>*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based</p> <p><input type="checkbox"/> FCBP dispense 21 capsules (1 cycle)</p> <p><input type="checkbox"/> For Male and Female NCBP: Mitte: _____ capsules or _____ cycles. Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed</p> <p>Physician to assure DVT prophylaxis in place: ASA or Warfarin or low molecular weight heparin or direct oral anticoagulant or none</p>	<p>Pharmacy Use for Lenalidomide: RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>
<p>STEROID* CHOOSE ONE One cycle = 28 days</p> <p>DEXAMETHASONE</p> <p><input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg (select one) PO once weekly, in the morning, on Days 1, 8, 15 and 22 x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one)</p> <p><input type="checkbox"/> dexamethasone _____mg PO once weekly in the morning, x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one)</p> <p><input type="checkbox"/> predniSONE _____mg PO once weekly in the morning, x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one)</p> <p><input type="checkbox"/> No Steroid</p> <p>*Refer to Protocol for steroid dosing options</p>	
<p>DOCTOR'S SIGNATURE: Physician RevaID ID: _____</p>	<p>SIGNATURE: UC:</p>

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DATE:

CARFILZOMIB

If patient is VZV seropositive and/or at physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg daily while on carfilzomib and for four weeks after discontinuation

CYCLE 1:

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

carfilzomib 56 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 one hour following each carfilzomib infusion

CYCLES 2-18:

carfilzomib 56 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 56 mg/m² x BSA* = _____ mg

Dose Modification: _____ mg/m² x BSA* = _____ mg

IV in 100 mL D5W over 30 minutes on Days

RETURN APPOINTMENT ORDERS

Book chemo on Days 1, 8, and 15

Return in **four** weeks for Doctor and Cycle _____

Last Cycle. Return in _____ week(s).

Laboratory: Blood work done prior to next cycle must be done less than or equal to 4 days prior to the start date

Cycle 1:

Day 1: Urea, magnesium, alkaline phosphatase, ALT, serum bilirubin, albumin, total protein, Serum Protein Electrophoresis and Serum Free Light Chain Levels

Days 1, 8 and 15: CBC & Diff, platelets, creatinine, sodium, potassium, calcium, phosphate, glucose, uric acid

Cycle 2 and subsequent cycles:

Day 1: Urea, magnesium, alkaline phosphatase, ALT, serum bilirubin, albumin, total protein, Serum Protein Electrophoresis and Serum Free Light Chain Levels

Days 1 and 15: CBC & Diff, platelets, creatinine, sodium, potassium, calcium, phosphate, glucose, uric acid

TSH every three months (i.e. prior to Cycles 4, 7, 10, 13, 16 etc)

Quantitative beta-hCG blood test for FCBP 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1

Quantitative beta-hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle

Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks

Urine protein electrophoresis every 4 weeks

Other tests: _____ Consults: _____

DOCTOR'S SIGNATURE:

**SIGNATURE:
UC:**