A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**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, Platelets** day of treatment
  - May proceed with carfilzomib day 1 dose 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 and CrCl as per protocol
  - May proceed with carfilzomib day 8 and 15 doses as written (if day 8 is given), 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 and CrCl as per protocol
  - May proceed with cyclophosphamide dose as written, for entire cycle, if day 1 lab is within 96 hours ANC greater than 1.0 x 10⁹/L, platelets greater than 80 x 10⁹/L and CrCl 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**
- **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:**
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: UMycARDEX

DOCTOR’S ORDERS

DATE:

CHEMOTHERAPY:
- 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

DEXAMETHASONE
Dexamethasone 20 mg PO twice weekly, in the morning, on days 1, 2, 8, 9, 15, 16, 22 and 23

CARFILZOMIB

□ CYCLE 1:
- Carfilzomib 20 mg/m2 x BSA* = _____ mg IV in 100 mL D5W over 30 minutes on days 1 and 2
- Carfilzomib 56 mg/m2 x BSA* = _____ mg IV in 100 mL D5W over 30 minutes on days 8, 9, 15 and 16
  *(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

□ CYCLE 2-onward:
- Carfilzomib 56 mg/m2 x BSA* = _____ mg IV in 100 mL D5W over 30 minutes on days 1, 2, 8, 9, 15 and 16
  *(cap BSA at 2.2)
Vital signs prior to EACH carfilzomib infusion

CYCLOPHOSPHAMIDE (if using)
Cyclophosphamide (if using) 300 mg/m²/day x BSA x (__________%) = __________mg PO daily on days 1, 8 and 15 (round to nearest 25 mg)

POST HYDRATION (Optional):
- 250 mL NS IV over 30 minutes

DOCTOR’S SIGNATURE: SIGNATURE:

UC:
**PROTOCOL CODE: UMycarDex**

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book chemo on days 1, 2, 8, 9, 15 and 16</td>
</tr>
<tr>
<td>☐ Return in <strong>four</strong> weeks for Doctor and Cycle _________</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in _______ week(s).</td>
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</tbody>
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| 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 |
| Day 1: Serum Protein Electrophoresis and/or Serum Free Light Chain Levels (CIRCLE APPROPRIATE) |
| Day 1, 8 and 15: CBC and diff, platelets, creatinine, sodium, potassium, calcium, phosphate, glucose, uric acid |

| Cycles 2 and subsequent cycles: |
| Day 1: Urea, magnesium, alkaline phosphatase, ALT, serum bilirubin, albumin, total protein |
| Day 1: Serum Protein Electrophoresis and/or Serum Free Light Chain Levels (CIRCLE APPROPRIATE) |
| Day 1 and 15: CBC & Diff, platelets, creatinine, sodium, potassium, calcium, phosphate, glucose, and uric acid |

☐ Other tests  
☐ Consults:  
☐ See general orders sheet for additional requests

| DOCTOR'S SIGNATURE: |
| SIGNATURE: |
| UC: |