**PROTOCOL CODE: UMYCARLD**

Patient RevAid #____________

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

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht________cm</th>
<th>Wt________kg</th>
<th>BSA________m²</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

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
☐ Other: ____________________

<table>
<thead>
<tr>
<th>PREHYDRATION:</th>
<th>SIGNATURE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle 1:</td>
<td>UC:</td>
</tr>
<tr>
<td>Pre-hydration: 250 mL NS IV over 30 minutes</td>
<td></td>
</tr>
<tr>
<td>Cycle 2 onward (optional):</td>
<td></td>
</tr>
<tr>
<td>☐ 250 mL NS IV over 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>

**DOCTOR’S SIGNATURE:**
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: UMycARLD**

**DOCTOR’S ORDERS**

**DATE:**

<table>
<thead>
<tr>
<th>CHEMOTHERAPY: LENALIDOMIDE</th>
<th>Pharmacy Use for Lenalidomide: RevAid confirmation number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>One cycle = 28 days</td>
<td></td>
</tr>
</tbody>
</table>

- [ ] lenalidomide* ______mg PO daily, in the evening, on Days 1 to 21 and off for 7 days
- [ ] lenalidomide* ______ mg PO __________________________________________
  (*available as 25 mg, 20mg, 15 mg, 10 mg, 5 mg and 2.5 mg capsules)
  *Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based
- [ ] FCBP dispense 21 capsules (1 cycle)
- [ ] For Male and Female NCBP:
  - Mitte: ________capsules or ________ cycles. Maximum 252 capsules (12 cycles).
  - Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

  *Physician to assure DVT prophylaxis in place: ASA or Warfarin or low molecular weight heparin or direct oral anticoagulant or none*

**STEROID* CHOOSE ONE**

**One cycle = 28 days**

<table>
<thead>
<tr>
<th>DEXAMETHASONE</th>
<th>Pharmacy Use for Lenalidomide: RevAid confirmation number:</th>
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<tbody>
<tr>
<td></td>
<td></td>
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- [ ] dexamethasone [ ] 40 mg or [ ] 20 mg PO once weekly, in the morning, on Days 1, 8, 15 and 22
  x _______ doses OR number of 28 day cycles ________
- [ ] dexamethasone _______mg PO __________________________, in the morning,
  x _______ doses OR number of 28 day cycles ________
- [ ] predniSONE _______mg PO ____________________________, in the morning,
  x _________ doses OR number of 28 day cycles ________
- [ ] No Steroid

*Refer to Protocol for steroid dosing options*

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**Physician Revaid ID:**

**UC:**
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

Day 1: Serum Protein Electrophoresis and/or Serum Free Light Chain Levels (CIRCLE APPROPRIATE)

Day 1, 8, 15: CBC & 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)

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

TSH Every three months

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

☐ Pregnancy blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle

☐ Other tests:

☐ Consults

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

UC: