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

Patient RevAid #_____

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

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:

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 10^9/L, Platelets greater than or equal to 10 x 10^9/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 10^9/L, Platelets greater than or equal to 10 x 10^9/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 10^9/L, Platelets greater than or equal to 30 x 10^9/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:**

DOCTOR'S ORDERS

DATE:

CHEMOTHERAPY:

LENALIDOMIDE

One cycle = 28 days

☐ 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 63 capsules (3 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

Pharmacy Use for Lenalidomide:

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

STEROID* CHOOSE ONE

One cycle = 28 days

DEXAMETHASONE

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** (select one) PO once weekly**,** in the morning**,** on Days 1, 8, 15 and 22 x ☐ _____ doses **OR** ☐ number of 28 day cycles _____ (select one)

☐ dexamethasone _____mg PO once weekly in the morning, x ☐ _____ doses OR ☐ number of 28 day cycles _____ (select one)

☐ predniSONE _____mg PO once weekly in the morning, x ☐ _____ doses **OR** ☐ number of 28 day cycles _____ (select one)

☐ No Steroid

*Refer to Protocol for steroid dosing options

DOCTOR'S SIGNATURE:

Physician Revaid ID: _____

SIGNATURE:

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/m^2 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 (SELECT 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 (SELECT APPROPRIATE)

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

☐ Other tests:

☐ Consults:

DOCTOR'S SIGNATURE:

SIGNATURE:
UC: