PROTOCOL CODE: UMYISACARD (Cycle 1)

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 # 1**

****Ensure Red Blood Cell Phenotype **and Group and Screen** for all patients prior to Cycle 1****

☐ Delay treatment _____ week(s)

☐ **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 10^9/L, platelets greater than or equal to 50 x 10^9/L and serum creatinine/CrCl as per protocol**

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

Proceed with treatment based on blood work from _____

STEROID: (select one)* RN to use patient's therapeutic steroid as pre-med for isatuximab.

30 minutes prior to isatuximab infusion:

dexamethasone 40 mg ☐ PO or ☐ IV in 50 mL NS over 15 minutes before isatuximab on Days 1, 8, 15 and 22

OR

dexamethasone 20 mg ☐ PO or ☐ IV in 50 mL NS over 15 minutes before isatuximab on Days 1, 8, 15 and 22

OR

☐ **predniSONE 100 mg** PO before isatuximab on Days 1, 8, 15, and 22

OR

☐ **hydrocortisone 100 mg** IV before isatuximab on Days 1, 8, 15, and 22

***Refer to Protocol for suggested dosing options**

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DATE:

ISATUXIMAB

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

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

30 minutes prior to isatuximab infusion:

dexamethasone or alternative steroid as ordered in steroid section

montelukast 10 mg PO prior to isatuximab

acetaminophen 650 mg PO prior to each isatuximab. Repeat **acetaminophen 650 mg** PO every 4 hours when needed if IV infusion exceeds 4 hours

Select one of the following:

☐ **loratadine 10 mg** PO prior to each isatuximab, then **diphenhydrAMINE 50 mg** IV every 4 hours when needed for isatuximab reaction

OR

☐ **diphenhydrAMINE 50 mg** ☐ PO or ☐ IV prior to each isatuximab. Repeat **diphenhydrAMINE 50 mg** IV every 4 hours when needed for isatuximab reaction

Optional (recommended for first isatuximab dose, see protocol):

☐ **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible with diphenhydrAMINE, if using) on Day 1

☐ **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible with diphenhydrAMINE, if using) on Days 8, 15, and 22

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

☐ **ondansetron 8 mg** PO prior to carfilzomib

☐ **Other:**

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

ISATUXIMAB

CYCLE 1, Day 1:

isatuximab 10 mg/kg x _____ kg = _____mg **IV in 250 mL NS (use 0.2 micron in-line filter)**

Infusion rate for Day 1:

Start at 25 mL/hour. If no infusion-related reactions after 60 minutes, increase by 25 mL/hour every 30 minutes to a maximum rate of 150 mL/hour

If BP falls to less than 80/50 mmHg or pulse increases to greater than 120 or if flushing, dyspnea, chills, rash, pruritus, vomiting, chest pain, throat tightness, cough, wheezing, or any other new acute discomfort occurs, stop isatuximab infusion and page physician.

Vitals monitoring and observation:
Vital signs immediately before the start of infusion, then every 30 minutes x 4, then every 1 to 2 hours until the end of infusion and at 30 minutes post infusion. Observe patient for 30 minutes after isatuximab infusion.

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DATE:

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

ISATUXIMAB continued

CYCLE 1, Day 8:

isatuximab 10 mg/kg x _____ kg = _____mg **IV in 250 mL NS (use 0.2 micron in-line filter)**

Infusion rate: Physician to determine rate of infusion

If no reaction in the previous infusion or reaction is Grade 2 or less:

☐ Start at 50 mL/hour. If no infusion-related reactions after 30 minutes, increase by 50 mL/hour for 30 minutes, then by 100 mL/hour until maximum 200 mL/hour

OR

If reaction in the previous infusion is Grade 3:

☐ Start at 25 mL/hour. If no infusion-related reactions after 60 minutes, increase by 25 mL/hour every 30 minutes to a maximum rate of 150 mL/hour.

Vital signs immediately before the start, at the end of the infusion and as needed.

CYCLE 1, Days 15 and 22:

isatuximab 10 mg/kg x _____ kg = _____mg **IV in 250 mL NS (use 0.2 micron in-line filter)**

Infusion rate for Days 15 and 22: Physician to determine rate of infusion

If no reaction in the previous infusion or reaction is Grade 2 or less:

☐ Infuse over 30 minutes

OR

If reaction in the previous infusion is Grade 3:

☐ Start at 100 mL/hour. If no infusion-related reactions after 60 minutes, increase by 50 mL/hour every 60 minutes to a maximum rate of 200 mL/hour.

Vital signs immediately before the start, at the end of the infusion and as needed.

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

PREHYDRATION (Optional- see protocol. May be given during isatuximab observation):

☐ 250 mL NS IV over 30 minutes prior to carfilzomib

CARFILZOMIB

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 m^2)

Vital signs prior to EACH carfilzomib infusion

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

DOSE MODIFICATION IF REQUIRED ON DAYS 8 AND/OR 15

carfilzomib 70 mg/m² x BSA* = _____ mg

☐ Dose Modification: _____ mg/m^2 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 ____ cycle(s).

OR

☐ **cyclophosphamide _____ mg** PO once weekly in the morning on Days _____ Dispense ____ cycle(s).

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for 14 doses. Dispense ____ cycle(s).

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DATE:	
RETURN APPOINTMENT ORDERS	
For Cycle 1, book chemo on Days 1, 8, 15 and 22 For Cycle 2 book chemo on Days 1, 8, and 15 ☐ Return in **four** weeks for Doctor and Cycle 2	
CBC & Diff, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, phosphate, random glucose, LDH, serum protein electrophoresis *and* serum free light chain levels every 4 weeks ☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks ☐ **Urine protein electrophoresis** every 4 weeks ☐ **Beta-2 microglobulin** every 4 weeks ☐ **CBC & Diff** on Days 8, 15, 22 ☐ **Creatinine, sodium, potassium** on Days 8, 15, 22 ☐ **Total bilirubin, ALT, alkaline phosphatase** on Days 8, 15, 22 ☐ **Random glucose** on Days 8, 15, 22 ☐ **Calcium, albumin** on Days 8, 15, 22 ☐ **Phosphate** Days 8, 15, 22 ☐ **CBC & Diff, platelets, peripheral smear, LDH, total and direct bilirubin, haptoglobin, DAT, creatinine, urea** ☐ **HBV viral load** prior to next cycle ☐ See general orders sheet for additional requests ☐ Consults ☐ Other tests:	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**