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

Patient RevAid ID:_____

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

Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L and eGFR or creatinine clearance 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)
☐ **ondansetron 8 mg** PO prior to carfilzomib
☐ Other:

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 ensure DVT prophylaxis in place: ☐ ASA or ☐ Warfarin or ☐ low molecular weight heparin or ☐ direct oral anticoagulant or ☐ none (select one)

Pharmacy Use for Lenalidomide dispensing:

Part Fill # 1
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 2
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 3
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Special Instructions

DOCTOR'S SIGNATURE:

Physician Revaid ID: _____

SIGNATURE:

UC:

DOCTOR'S ORDERS

DATE:

STEROID (select one)*

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** (select one) PO once weekly**,** in the morning**,** on Days 1, 8, 15 and 22 of each cycle

☐ **dexamethasone _____mg** PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ **predniSONE _____mg** PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ **No Steroid**

***Refer to Protocol for steroid dosing options**

PREHYDRATION:

Cycle 1:

Pre-hydration: 250 mL NS IV over 30 minutes

Cycle 2 onward (optional- see protocol):

☐ 250 mL NS IV over 30 minutes

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

CARFILZOMIB

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

☐ **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 30 minutes following each carfilzomib infusion

☐ **CYCLES 2 to 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 _____

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: MYCARLD

DATE:

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

POST HYDRATION (Optional- see protocol):

☐ 250 mL NS IV over 30 minutes after carfilzomib

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).

CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, phosphate, LDH, random glucose, serum protein electrophoresis *and* serum free light chain levels every 4 weeks

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

☐ **Urine protein electrophoresis** every 4 weeks
☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks
☐ **Beta-2 microglobulin** every 4 weeks
☐ **CBC & Diff, platelets** Days 8, 15, 22
☐ **Creatinine, sodium, potassium** Days 8, 15, 22
☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22
☐ **Random glucose** Days 8, 15, 22
☐ **Calcium, albumin** Days 8, 15, 22
☐ **Phosphate** Days 8, 15, 22
☐ **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: