



Provincial Health Services Authority

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: MYBORREL

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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: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets on 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 10⁹/L, platelets greater than or equal to 50 x 10⁹/L and creatinine clearance as per protocol					
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity : _____					
Proceed with treatment based on blood work from _____					
TREATMENT:					
• Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily					
bortezomib <input type="checkbox"/> 1.5 mg/m ² or <input type="checkbox"/> 1.3 mg/m ² or <input type="checkbox"/> 1 mg/m ² or <input type="checkbox"/> 0.7 mg/m ² or <input type="checkbox"/> 0.5 mg/m ² (select one) x BSA = _____ mg subcutaneous injection on Days 1, 8, 15 and 22					
OPTIONAL CYCLOPHOSPHAMIDE:					
<input type="checkbox"/> cyclophosphamide 500 mg PO once weekly in the morning on Days 1, 8, 15, and 22. Dispense _____ cycles.					
OR					
<input type="checkbox"/> cyclophosphamide _____ mg PO once weekly in the morning on Days _____ Dispense _____ cycles.					
OR					
<input type="checkbox"/> cyclophosphamide 50 mg PO once in the morning every 2 days for _____ doses. Dispense _____ cycles					
STEROID (select one)*					
<input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO in morning on Days _____ (write in) of each cycle					
<input type="checkbox"/> dexamethasone _____ mg PO in morning on Days _____ (write in) of each cycle					
<input type="checkbox"/> predniSONE _____ mg PO in morning on Days _____ (write in) of each cycle					
<input type="checkbox"/> No Steroid					
*Refer to Protocol for suggested dosing options					
NB: Bortezomib twice weekly dosing option available (see protocol). Orders should be handwritten on a separate order.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:



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Date:	
RETURN APPOINTMENT ORDERS	
Return in <u>four</u> weeks for Doctor and Cycle _____. Book chemo on Days 1, 8, 15 and 22 <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<p>Prior to each cycle: CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis <u>and</u> serum free light chain levels</p> <input type="checkbox"/> Urine protein electrophoresis prior to each cycle <input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) prior to each cycle <input type="checkbox"/> Beta-2 microglobulin prior to each cycle <input type="checkbox"/> CBC & Diff, platelets Days 8, 15, 22 <input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22 <input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22 <input type="checkbox"/> Random glucose Days 8, 15, 22 <input type="checkbox"/> Calcium, albumin Days 8, 15, 22 <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: