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** 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 _____.

OPTIONAL: If dexamethasone not given as part of the treatment regimen, and concerns regarding infusion reactions, 30 minutes prior to carfilzomib:

☐ **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, 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** 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
☐ **HBV viral load** prior to next cycle
☐ **Other tests:**
☐ **Consults:**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: