PROTOCOL CODE: UMYISACARD (Cycle 2+)

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

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: _____

****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.

☐ **PO Only**

☐ **dexamethasone** _____ **mg** PO once weekly on Days 1, 8, 15, and 22. Take dose 30 minutes prior to isatuximab and on weeks without isatuximab, take dose in the morning

OR

☐ **predniSONE** _____ **mg** PO once weekly on Days 1, 8, 15, and 22. Take dose 30 minutes prior to isatuximab and on weeks without isatuximab, take dose in the morning

Pharmacy to dispense four doses for Days 1, 8, 15 and 22.

OR

☐ **PO/IV option**

dexamethasone _____ **mg IV** in 50 mL NS over 15 minutes given 30 minutes prior to treatment on Days 1, 8 and 15

AND

dexamethasone _____ **mg PO** once weekly on Day 22. Patient to take dose in the morning.

Pharmacy to dispense one dose for Day 22.

OR

☐ No steroid

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

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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 _____.

- If no reaction after 4 consecutive doses of isatuximab, may discontinue acetaminophen, loratadine/diphenhydrAMINE, famotidine and montelukast

30 minutes prior to isatuximab infusion:

dexamethasone PO or **predniSONE** as ordered in steroid section, above

☐ **montelukast 10 mg** PO prior to each 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 (See protocol):

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

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 2 onwards, Days 1 and 15:

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

Infusion rate for cycle 2 onwards: 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. Vital signs not required after 4 treatments with no reaction.

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DATE:

****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 CYCLE 2 onward:

carfilzomib 70 mg/m^2 x BSA* = _____ mg

IV in 100 mL D5W over 30 minutes on Days 1, 8 and 15

*(cap BSA at 2.2 m^2)

Vital signs prior to EACH carfilzomib infusion

DOSE MODIFICATION IF REQUIRED ON DAYS 8 AND/OR 15

carfilzomib 70 mg/m^2 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 ____ cycles.

OR

☐ **cyclophosphamide _____ mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for 14 doses. Dispense ____ cycles.

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DATE:	

RETURN APPOINTMENT ORDERS

Book chemo on Days 1, 8, and 15 ☐ Return in **four** weeks for Doctor and Cycle _____ ☐ Return in **eight** weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles. ☐ Return in **twelve** weeks for Doctor and Cycles _____, _____ and _____. Book chemo x 3 cycles ☐ Last Cycle. Return in _____ week(s).	
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 ☐ **HBV viral load** prior to next cycle ☐ CBC & Diff, platelets, peripheral smear, LDH, total and direct bilirubin, haptoglobin, DAT, creatinine, urea ☐ See general orders sheet for additional requests ☐ Other tests: ☐ Consults	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**