Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Carfilzomib (KYLOPRIS) Non-Oncology Infusion for Solid Organ Transplant Rejection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Antiviral prophylaxis should be ordered to decrease the risk of herpes zoster reactivation with carfilzomib.
2. Hypertension has occurred with carfilzomib; hypertensive crisis and hypertensive emergency have also been reported; some events were fatal. Blood pressure should be monitored and managed throughout treatment.
3. Renal insufficiency, acute kidney failure, and kidney failure have been reported with carfilzomib; some events have been fatal.
4. Carfilzomib has been associated with new-onset or worsening of heart failure, pulmonary edema, decreased ejection fraction, cardiomyopathy, myocardial ischemia, and myocardial infarction; some events have been fatal. Cardiac toxicity has occurred in patients with normal ventricular function at baseline. Consider a baseline ECHO, troponin, and BNP.
5. Hemorrhage have been reported, including GI, intracranial, and pulmonary hemorrhage and epistaxis.

LABS:

- ☐ CMP, Routine, ONCE, every 1 week
- ☐ CBC w/diff, Routing, ONCE, every 1 week

NURSING ORDERS:

1. TREATMENT PARAMETER 1: Labs drawn day 1 of each week: Hold treatment and notify provider for ANC less than 1000, Platelets less than 50,000, Total Bilirubin greater than 3x ULN, AST greater than 5x ULN, serum creatinine greater than or equal to 2x baseline, or estimated Creatinine Clearance less than 15 mL/min.
2. TREAMENT PARAMETER 2: Hold treatment and notify provider for BP greater than 160/100 mmHg.

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PRE-MEDICATIONS:

- ☐ diphenhydrAMINE tablet, 50 mg, by mouth, ONCE AS NEEDED, if diphenhydrAMINE not given, every visit. Administer 30 minutes prior to infusion. Give either diphenhydrAMINE or loratadine, not both.
- ☐ loratadine, 10 mg, by mouth, ONCE AS NEEDED, if diphenhydrAMINE not given, every visit. Administer 30 minutes prior to infusion. Give either diphenhydramine or loratadine, not both.
- ☐ acetaminophen, 650 mg, by mouth, ONCE, every visit
- ☐ prednisone, 40 mg, by mouth, ONCE, every visit
- ☐ ondansetron 4 mg ODT, by mouth, ONCE AS NEEDED, for nausea and vomiting, every visit

PRE-HYDRATION:

- ☐ sodium chloride 0.9% bolus, 250 mL, intravenous, ONCE, over 30 minutes, to be given prior to carfilzomib, every visit

MEDICATIONS:

Guidelines for ordering: Patients with a body surface area (BSA) greater than 2.2 m2 should be dosed based upon a maximum BSA of 2.2 m2. Dose adjustments for weight changes of less than or equal to 20% are not necessary, per manufacturer labeling.

carfilzomib (Kylopris), 20 mg/m2 in 50 mL of dextrose 5%, intravenous, administer over 10 minutes, ONCE, on the following treatment days:

- ☐ Day 1 and Day 2
- ☐ Day 8 and Day 9
- ☐ Day 15 and Day 16

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – if hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. DiphenhydrAMINE (BENADRYL) injection, 25–50 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.

OHSU Health **Oregon Health & Science University Hospital and Clinics Provider's Orders** ADULT AMBULATORY INFUSION ORDER **Carfilzomib (KYLOPRIS) Non-Oncology Infusion for Solid Organ Transplant Rejection** Page 3 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

Contact Referral Team directly for assistance at the centralized numbers below (do not fax/call individual clinics). **INFUSION REFERRAL TEAM** **Fax completed orders to (503) 346-8058** Phone (providers only) (971) 262-9645	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
	☐ **Non-Legacy community providers only** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216
Infusion orders located at: www.ohsuknight.com/infusionorders	Referral team will consider other locations as appropriate if selected site is not available, if treatment is urgent, or for patient preference.	