KYPROLIS® (CARFILZOMIB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** _____ ☐ inches ☐ cm	**Weight:** _____ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Is this the first dose? ☐ **Yes** – Date of first dose: _____ ☐ **No** – Date of last dose: _____

Kyprolis®(carfilzomib) Prescription

☐ **Kyprolis Combination therapy with Sarclisa *(complete separate Sarclisa Prescriber Order Form)* and dexamethasone**

- Kyprolis 20 mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week
- Kyprolis 56 mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.
- Dexamethasone 20mg via slow IV push on the days of Kyprolis administration, prior to Kyprolis
- Dexamethasone 20mg PO on the Day 22 in Cycle 2 and beyond and on Day 23 in all cycles

☐ **Kyprolis 20/56 mg/m² Monotherapy with dexamethasone**

- Kyprolis 20mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week
- Kyprolis 56 mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.
- Dexamethasone 8 mg PO 30 minutes prior to Kyprolis administration

☐ **Kyprolis 20/27 mg/m²**

- Kyprolis 20mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week
- Kyprolis 27mg/m² diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.
- Dexamethasone 4mg PO 30 minutes prior to Kyprolis administration

☐ **Kyprolis 70 mg/m² diluted in 100 mL of Dextrose 5% IV over 30 minutes weekly until disease progression or unacceptable toxicity.**

- Dexamethasone 40mg PO 30 minutes prior to Kyprolis administration

☐ **Other:**_____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Hydration orders

- 0.9% Sodium Chloride 500 mL at ____mL/hr prior to each dose in Cycle 1

☐ Other:_____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to administer doses intravenously in the alternate care setting. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

