

<b>KYPROLIS® (CARFILZOMIB) PRESCRIBER ORDER FORM</b>			
Patient Name:		Date of Birth:	Gender:
Address:			
Phone:	Height: _____ <input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	
Clinical Information			
Primary Diagnosis Description:		ICD-10 Code:	
Is this the first dose? <input type="checkbox"/> Yes – Date of first dose: _____ <input type="checkbox"/> No – Date of last dose: _____			
Kyprolis®(carfilzomib) Prescription			
<div style="margin-bottom: 10px;"> <input type="checkbox"/> <b>Kyprolis Combination therapy with Sarclisa (<i>complete separate Sarclisa Prescriber Order Form</i>) and dexamethasone</b> <ul style="list-style-type: none"> <li>Kyprolis 20 mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week</li> <li>Kyprolis 56 mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.</li> <li>Dexamethasone 20mg via slow IV push on the days of Kyprolis administration, prior to Kyprolis</li> <li>Dexamethasone 20mg PO on the Day 22 in Cycle 2 and beyond and on Day 23 in all cycles</li> </ul> </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> <b>Kyprolis 20/56 mg/m<sup>2</sup> Monotherapy with dexamethasone</b> <ul style="list-style-type: none"> <li>Kyprolis 20mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week</li> <li>Kyprolis 56 mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.</li> <li>Dexamethasone 8 mg PO 30 minutes prior to Kyprolis administration</li> </ul> </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> <b>Kyprolis 20/27 mg/m<sup>2</sup></b> <ul style="list-style-type: none"> <li>Kyprolis 20mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days x 1 week</li> <li>Kyprolis 27mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% administered IV over 30 minutes twice weekly on 2 consecutive days until disease progression or unacceptable toxicity.</li> <li>Dexamethasone 4mg PO 30 minutes prior to Kyprolis administration</li> </ul> </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> <b>Kyprolis 70 mg/m<sup>2</sup> diluted in 100 mL of Dextrose 5% IV over 30 minutes weekly until disease progression or unacceptable toxicity.</b> <ul style="list-style-type: none"> <li>Dexamethasone 40mg PO 30 minutes prior to Kyprolis administration</li> </ul> </div> <div> <input type="checkbox"/> <b>Other:</b> _____         </div>			
Ancillary Orders			
<b>Anaphylaxis Kit</b> Dosage: <ul style="list-style-type: none"> <li>Epinephrine 0.3 mg (&gt; 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (&lt; 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.</li> <li>Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>0.9% Sodium Chloride 500 mL (&gt; 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 &gt; 5 on pain scale.</li> </ul>			
<b>Hydration orders</b> <ul style="list-style-type: none"> <li>0.9% Sodium Chloride 500 mL at _____ mL/hr prior to each dose in Cycle 1</li> </ul> <input type="checkbox"/> Other: _____			
<b>IV Flush Orders</b> <div style="margin-left: 20px;"> <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.           <input type="checkbox"/> <u>Implanted Port:</u> 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.           </div>			
<b>Lab Orders</b> <div style="margin-left: 20px;"> <input type="checkbox"/> No labs ordered at this time.           <input type="checkbox"/> Other: _____         </div> <p>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.</p>			
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>			
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: <b>713-983-4647</b>			
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