MIC | METRO INFUSION CENTER

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Bortizomib (Velcade)

Please check the box corresponding to the weight used for dose calculation.

Height: _____cm Weight: _____kg ☐ Actual

☐ Call for weight change greater than 10% from baseline
☐ No dose modifications required for any weight change

BSA: _____ m^2
☐ DuBois
☐ Mosteller

Laboratory or Other Tests Related to Chemotherapy: **Provider to select preference below**
☐ CBC/Differential prior to each cycle
☐ CMP at the start of each cycle

Dosing Guidelines/ Parameters: **Provider to check box that they agree with the dosing calculations**
☐ Ok to treat with ANC greater than or equal to 1500; Platelets greater than or equal to 100,000
☐ Treat with ANC greater than or equal to _____; Platelets greater than or equal to_____
☐ Call for LFT's 2x ULN
Other:

Hydration Orders: Not Required

Premedication and Antiemetic Orders: ☐ Not Required (minimal emetogenic potential)

Treatment Orders:

DRUG	DOSE	CALCULATED DOSE	ROUTE	DAYS TO BE GIVEN
☐ Bortizomib (Velcade)	1.3 mg/M2	_____mg	SQ	☐ Day 1; 4; 8; 11 of each cycle (must have at least 72 hours between doses) ☐ Every week ☐ Every 2 weeks
☐ Bortizomib (Velcade)	1.3 mg/M2	_____mg	**IVP** over 3-5 seconds	☐ Day 1; 4; 8; 11 of each cycle (must have at least 72 hours between doses) ☐ Every week ☐ Every 2 weeks

Date of first treatment: _____/subsequent treatments may be given +/- 2 days
This order is good for 1 year from the date ordered

Other:
Assure that when you administer SQ, use air lock and administer at 90 degree angle over 30 seconds in thigh or abdomen only to prevent skin irritation
Oral cancer treatment patient is on: _____

Call referring provider for:

- Peripheral neuropathy that is impacting the patient's life
- Severe constipation or diarrhea
- LFT abnormalities
- Low blood counts

Other reasons to call:

DATE	Referring Provider:_____ _____ Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED