



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 <input type="checkbox"/> Actual <input type="checkbox"/> Call for weight change greater than 10% from baseline <input type="checkbox"/> No dose modifications required for any weight change	BSA: _____ m² <input type="checkbox"/> DuBois <input type="checkbox"/> Mosteller
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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

 Use standard treatment parameters : 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
<input type="checkbox"/> Bortizomib (Velcade)	1.3 mg/kg	_____mg	SQ	<input type="checkbox"/> Day 1; 4; 8; 11 of each cycle (must have at least 72 hours between doses) <input type="checkbox"/> Every week <input type="checkbox"/> Every 2 weeks
<input type="checkbox"/> Bortizomib (Velcade)	1.3 mg/kg	_____mg	IVP over 3-5 seconds	<input type="checkbox"/> Day 1; 4; 8; 11 of each cycle (must have at least 72 hours between doses) <input type="checkbox"/> Every week <input type="checkbox"/> 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 to prevent skin irritation
 This drug is hazardous and thus can be mixed by pharmacy

Call referring provider for:

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

DATE	Referring Provider: _____	Telephone# _____
	<small>SIGNATURE REQUIRED</small>	<small>PRINTED NAME REQUIRED</small>