CYBORP (cyclophosphamide-bortezomib-predniSONE)*
*drug in italics is IV drug given in hospital or cancer centre

Diagnosis: Multiple myeloma

Clinical Verification
☐ Bloodwork and other clinical parameters have been verified by a regulated health professional
☐ Prescription has been verified by an nurse or pharmacist

Height = ________ cm Weight = _________ kg
Body Surface Area (BSA) = _________ m²

Cycle #: _____; Cycles repeat every 28 days

Rx (Start Date/Day 1: ___________)

cyclophosphamide 300 mg/m²* x BSA x ____% dose* = ______ mg PO on Days 1, 8, 15, 22

Mitte: ______ x 25 mg tablets and/or ___ x 50 mg tablets (ODB general benefit)
predniSONE 100 mg x ____% dose* = _________ mg PO in the morning with food every 2 days

Mitte: _______ x 50 mg tablets and/or ____ x 5 mg tablets (ODB general benefit)

*Dose modification for: □ Age/performance status □ Hematologic toxicity □ Hepatic function □ Renal function □ Corticosteroid toxicity □ Other ___________________________________________________________________________________

NO Repeats

Supportive Care Rx
☐ 5-HT₃ receptor antagonist (centre choice) pre-chemotherapy on Day(s)____

Mitte: _______ Repeat: ____ LU Code____

☐ dexamethasone 8 mg PO on Day(s): _______  Mitte: _____ Repeat: __________

☐ prochlorperazine 10 mg PO q6h PRN nausea  Mitte: _____ Repeat: ______

☐ antiviral prophylaxis (if applicable): ____________________________  Mitte: _____ Repeat: ______

☐ antibiotic prophylaxis (if applicable): ____________________________  Mitte: _____ Repeat: ______

Allergies (also specify reaction)  ☐ None known

Patient information (including name, address, date of birth, phone number)

Patient Name ____________________________ Date ____________________________
Print name ____________________________ Signature ____________________________

Prescriber information (name, office phone number/fax, address if different than hospital address)

Physician Signature ____________________________ CPSO# ____________________________
OPTIONAL INFORMATION

- Patient has been counseled by an Oncology Pharmacist

  Print name __________________________ Signature __________________________ Date ________________

OR

- Requires counseling
- Drug interaction assessment

Drug-specific information
For the complete information, please refer to the Cancer Care Ontario drug information sheets available at
www.cancercare.on.ca/drugformulary