PROTOCOL CODE: MYDARCBDF (IV Cycle 2+)

DOCTOR'S ORDERS

Ht_____cm Wt _____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle: _____

****Ensure Red Blood Cell Phenotype **and Group and Screen** for all patients prior to Cycle 1****

☐ Delay treatment _____ week(s)

☐ **CBC & Diff**, **Platelets** day of treatment

- Proceed with bortezomib dose day 1 as written, if within 96 hours **ANC greater than or equal to 0.5 x 10^9/L, platelets greater than or equal to 30 x 10^9/L, bilirubin less than or equal to 1.5 x upper limit of normal**
- If CBC prior to day 1 show ANC less than 1.5 x 10^9/L or platelets less than 100 x 10^9/L then:
  - May proceed with bortezomib Days 8, 15, 22 as written, if within 48 hours **ANC greater than or equal to 0.5 x 10^9/L, platelets greater than or equal to 30 x 10^9/L**
- Proceed with cyclophosphamide dose as written, for entire cycle, if day 1 lab is within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 80 x 10^9/L and CrCl greater than or equal to 10 mL/min**
- Proceed with daratumumab day 1 dose as written, if within 96 hours (or within 48 hours for day 15) **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Hematology:** _____ ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

CYCLOPHOSPHAMIDE – Cycles 2 to 9

cyclophosphamide 300 mg/m^2/day x BSA x (_____%) = _____mg PO weekly on days 1, 8, 15 and 22 (round to nearest 25 mg)

BORTEZOMIB – Cycles 2 to 9

- If patient is VZV seropositive and/or at physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg daily while on bortezomib and/or daratumumab and for four weeks after discontinuation

bortezomib ☐ **1.5 mg/m^2** or ☐ **1.3 mg/m^2** or ☐ **1 mg/m^2** or ☐ **0.7 mg/m^2** x BSA =_____ mg

subcutaneous injection weekly on days 1, 8, 15 and 22

STEROID: RN to use patient's therapeutic steroid (if applicable) as pre-med for daratumumab - refer to protocol

Cycles 2 to 9

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** PO once weekly on days 1, 8, 15, and 22. Take dose prior to daratumumab and on weeks without daratumumab, take dose in the morning, *OR*

☐ **dexamethasone _____mg** PO once weekly on days 1, 8, 15, and 22. Take dose prior to daratumumab and on weeks without daratumumab, take dose in the morning, *OR*

☐ **predniSONE _____mg** PO once weekly on days 1, 8, 15, and 22. Take dose prior to daratumumab and on weeks without daratumumab, take dose in the morning

☐ No steroid

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:

****Have Hypersensitivity Reaction Tray and Protocol Available****

DARATUMUMAB

If patient is VZV seropositive and/or at physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg daily while on bortezomib and/or daratumumab and for 4 weeks after discontinuation

DARATUMUMAB PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm.

dexamethasone as ordered in steroid section

☐ **montelukast 10 mg** PO prior to each daratumumab

acetaminophen 650 mg PO prior to each daratumumab. Repeat **acetaminophen 650 mg** PO every 4 hours when needed

Select one of the following:

☐ **loratadine 10 mg** PO prior to each daratumumab, then **diphenhydrAMINE 50 mg** IV every 4 hours when needed

OR

☐ **diphenhydrAMINE 50 mg** ☐PO or ☐ IV prior to each daratumumab. Repeat **diphenhydramine 50 mg** IV every 4 hours when needed

DARATUMUMAB

☐ **CYCLE 2, Days 1, 8, 15, and 22:**

daratumumab 16 mg/kg x _____ kg = _____mg IV in 500 mL NS (use 0.2 micron in-line filter)

☐ **CYCLES 3 to 6, Days 1 and 15:**

daratumumab 16 mg/kg x _____ kg = _____mg IV in 500 mL NS (use 0.2 micron in-line filter)

☐ **CYCLES 7 to 9, Day 1:**

daratumumab 16 mg/kg x _____ kg = _____mg IV in 500 mL NS (use 0.2 micron in-line filter)

☐ **CYCLE 10 onwards, Day 1:**

daratumumab 16 mg/kg x _____ kg = _____ mg IV in 500 mL NS (use 0.2 micron in-line filter) x ____ cycle(s)
(max 3 cycles)

Infusion rate for cycle 2 onwards: Physician to determine rate of infusion

If no reaction in the previous infusion or reaction is Grade 2 or less:

☐ Start at 200 mL/h. If no infusion - related reactions after 30 minutes, infuse the remainder at 450 mL/h (Rapid infusion)

OR If reaction in the previous infusion is Grade 3:

☐ Start at 100 mL/h. If no infusion-related reactions after 60 minutes, increase by 50 mL/h every 60 minutes to a maximum rate of 200 mL/h. Refer to protocol for modified starting rate if previous infusion reactions were experienced during infusion rate of greater than or equal to 100 mL/h (Slow infusion)

Vitals monitoring:

Vital signs immediately before the start, at the end of the infusion and as needed. Observe patient for 30 minutes after infusion. (Vitals and observation post-infusion not required after 3 treatments with no reaction).

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:	
RETURN APPOINTMENT ORDERS	
For Cycles 3 to 9 book chemo on days 1, 8, 15, 22 For Cycles 10 and subsequent, book chemo on day 1 ☐ Return in **four** weeks for Doctor and Cycle _____ ☐ Return in **eight** weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles. ☐ Return in **twelve** weeks for Doctor and Cycles _____, _____ and _____. Book chemo x 3 cycles ☐ Last Cycle. Return in _____ week(s).	
Laboratory: Blood work done prior to next cycle must be done less than or equal to 4 days prior to the start date **Day 1**: CBC & Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin, serum protein electrophoresis, serum free light chain levels CBC & Diff, platelets on Day 8, 15, and 22 for current cycle if ANC on Day 1 is less than 1.5 or Platelets are less than 100: ☐ **CBC & Diff, platelets** prior to Day 8, 15, and 22 treatment **Cycles 2 to 6: Day 15:** CBC & Diff, platelets If clinically indicated: ☐ immunoglobulin panel ☐ urine protein electrophoresis ☐ sodium, potassium ☐ ALT ☐ bilirubin ☐ creatinine ☐ See general orders sheet for additional requests ☐ Other tests: ☐ Consults	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**