PROTOCOL CODE: MYDARLDF (IV Cycle 2+)

Patient RevAid #_____

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: _____

Risk Category: ☐ **Female of Childbearing Potential (FCBP) Rx valid for 7 days**

Risk Category: ☐ **Male or Female of non-Childbearing Potential (NCBP)**

****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

- May proceed with daratumumab Day 1 doses as written, if within 96 hours (or within 48 h on days 8, 15, 22) **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**
- May proceed with lenalidomide doses as written, if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 30 x 10^9/L, eGFR as per protocol**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

LENALIDOMIDE

☐ lenalidomide* _____mg PO daily, in the evening, on days 1 to 21 and off for 7 days

☐ lenalidomide* _____ mg PO _____

(*available as 25 mg, 20 mg, 15 mg, 10 mg, 5 mg and 2.5 mg capsules)

*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based

☐FCBP dispense 21 capsules (1 cycle)

☐For Male and Female NCBP:

Mitte: _____capsules or _____ cycles. Maximum 63 capsules (3 cycles).

Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

Physician to assure DVT prophylaxis in place: ASA, Warfarin, low molecular weight heparin or direct oral anticoagulant or none

Pharmacy Use for Lenalidomide:

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

DOCTOR'S SIGNATURE:

Physician Revaid ID:

SIGNATURE:

UC:

PROTOCOL CODE: MYDARLDF (IV Cycle 2+)

DATE:

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

CYCLE #_____ (Cycle 2 onwards)

☐ **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 *x* _____ doses OR number of 28 day cycles_____ *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 x _____ doses OR number of 28 day cycles_____ *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 x _____ doses OR number of 28 day cycles_____ *OR*

☐ No Steroid

****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 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)

☐ **CYCLE 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) x ____ cycle(s) (max 2 cycles)

☐ **CYCLE 7 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 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 6, book chemo on days 1 and 15

For Cycle 7 onwards, 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

TSH every three months (i.e. prior to Cycles 4, 7, 10, 13, 16 etc)

Cycles 3 to 4:

☐ CBC & Diff, platelets, creatinine, calcium every two weeks

Cycles 3 to 6:

Day 1: CBC & Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin, serum protein electrophoresis, serum free light chain levels

If clinically indicated: ☐ immunoglobulin panel ☐ urine protein electrophoresis

Day 15: CBC & diff, platelets

If clinically indicated: ☐ sodium, potassium ☐ ALT ☐ bilirubin ☐ creatinine

Cycle 7 onwards:

Day 1: CBC & Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin, serum protein electrophoresis, serum free light chain levels

If clinically indicated: ☐ immunoglobulin panel ☐ urine protein electrophoresis

☐ Quantitative beta-hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle

☐ See general orders sheet for additional requests

☐ Other tests:

☐ Consults:

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: