PROTOCOL CODE: MYDARLD (IV Cycle 1)

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 #: 1**

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** day of treatment

Proceed with all medications as written, if within 96 hours of Day 1: **ANC greater than or equal to 1 x 10^9/L, platelets greater than or equal to 50 x 10^9/L, and eGFR or creatinine clearance as per protocol**

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

Proceed with treatment based on blood work from _____

LENALIDOMIDE

One cycle = 28 days

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

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

☐ **lenalidomide*** _____ **mg** PO _____

MITTE: (*available as 25 mg, 20mg, 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: 21 capsules (1 cycle).

Physician to ensure DVT prophylaxis in place: ☐ ASA, ☐ Warfarin, ☐ low molecular weight heparin, ☐ direct oral anticoagulant or ☐ none (select one)

Pharmacy Use for Lenalidomide dispensing:

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

DOCTOR'S SIGNATURE:

Physician Revaid ID:

SIGNATURE:

UC:

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DATE:

☐ **CYCLOPHOSPHAMIDE – Cycles 1 to 8**

☐ **cyclophosphamide 500 mg** PO once weekly in the morning on Days 1, 8, 15, and 22. Dispense ____ cycles.

OR

☐ **cyclophosphamide** _____ **mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for _____ doses. Dispense ____ cycles.

STEROID: RN to use patient's therapeutic steroid as pre-med for daratumumab - refer to protocol.

Standard Regimen: daratumumab full dose administered on Cycle 1 Day 1

☐ **dexamethasone** ☐ **40 mg or** ☐ **20 mg** PO before daratumumab on Days 1, 8, 15 and 22

OR

☐ **predniSONE 100 mg** PO before daratumumab on Days 1, 8, 15 and 22

OR

Alternative Regimen: daratumumab split dose administered on Cycle 1 Day 1 and Day 2

☐ **dexamethasone 20 mg** PO before daratumumab on Days 1 and 2, and **40mg** before daratumumb on Days 8, 15, 22

OR

☐ **dexamethasone 20 mg** PO before daratumumab on Days 1 and 2 and **20mg** before daratumumb on Days 8, 15, 22

OR

☐ **predniSONE 50 mg** PO before daratumumab on Days 1 and 2, and **prednisone 100mg** before daratumumb on Days 8, 15, 22

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

DARATUMUMAB

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

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

dexamethasone as ordered in steroid section

montelukast 10 mg PO prior to daratumumab on Day 1 (and Day 2 if on alternative regimen)

☐ **montelukast 10 mg** PO prior to daratumumab on Days 8, 15 and 22

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

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

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

DATE:

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

Standard regimen: daratumumab full dose administered on Cycle 1 Day 1

☐ **CYCLE 1, Day 1:**

daratumumab (First dose) 16mg/kg x _____ kg = _____mg **IV in 1000mL NS (use 0.2 micron in-line filter)**

OR

Alternative regimen: daratumumab split dose administered on Cycle 1 Day 1 and Day 2

☐ **CYCLE 1, Days 1 and 2**

daratumumab 8mg/kg x _____ kg = _____mg **IV in 500mL NS (use 0.2 micron in-line filter)**

Infusion rate for Day 1, (and Day 2, if Alternative regimen):

Start at 50 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
If BP falls to less than 80/50 mmHg or pulse increases to greater than 120 or if flushing, dyspnea, chills, rash, pruritis, vomiting, chest pain, throat tightness, cough, wheezing, or any other new acute discomfort occurs, stop daratumumab infusion and page physician.

Vitals monitoring:
Vital signs immediately before the start of infusion, then every 30 minutes x 4, then every 1-2 hours until the end of infusion and at 30 minutes post infusion. Observe patient for 30 minutes after each daratumumab infusion

☐ **CYCLE 1, Day 8**:
daratumumab 16mg/kg x _____ kg = _____mg **IV in 500mL NS (use 0.2 micron in-line filter)**

Infusion rate: 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 50 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 (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.

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

PROTOCOL CODE: MYDARLD (IV Cycle 1)

DATE:

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

CYCLE 1, Days 15 and 22:
daratumumab 16mg/kg x _____ kg = _____mg **IV in 500mL NS (use 0.2 micron in-line filter)**

Infusion rate for Days 15 and 22: 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 not required after 3 treatments with no reaction).

RETURN APPOINTMENT ORDERS

☐ STANDARD REGIMEN: For Cycle 1, book chemo on Days 1, 8, 15 and 22

☐ ALTERNATIVE REGIMEN: For Cycle 1, book chemo on Days 1, 2, 8, 15 and 22

For Cycle 2 book chemo on Days 1, 8, 15, 22
Return in **four** weeks for Doctor and Cycle 2

CBC & Diff, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis and serum free light chain levels every 4 weeks

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

☐ **Urine protein electrophoresis** every 4 weeks
☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks
☐ **Beta-2 microglobulin** every 4 weeks
☐ **CBC & Diff** Days 8, 15, 22
☐ **Creatinine, sodium, potassium** Days 8, 15, 22
☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22
☐ **Random glucose** Days 8, 15, 22
☐ **Calcium, albumin** Days 8, 15, 22
☐ **Quantitative beta-hCG blood test for FCBP** 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1
☐ **Quantitative β-hCG blood test for FCBP** less than or equal to 7 days prior to cycle 2
☐ **HBV viral load** prior to next cycle
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: