PROTOCOL CODE: MYDARLD (IV Cycle 2+)

Patient RevAid #_____

DOCTOR'S ORDERS

Ht _____**cm** **Wt** _____**kg** **BSA**_____**m²**

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

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

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:

Part Fill # 1
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 2
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 3
RevAid confirmation number: _____
Lenalidomide lot number: _____
Pharmacist counsel (initial): _____

Special Instructions

DOCTOR'S SIGNATURE:

Physician Revaid ID:

SIGNATURE:

UC:

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☐ **CYCLOPHOSPHAMIDE – Cycles 1 to 8 (☐ Cycle 9 onwards optional)**

☐ **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 (select one)* RN to use patient's therapeutic steroid (if applicable) as pre-med for daratumumab

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

***Refer to Protocol for suggested dosing options**

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

PROTOCOL CODE: MYDARLD (IV Cycle 2+)

DATE:

****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 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 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 30minutes after infusion (vitals and observation post- infusion not required after 3 treatments with no reaction).

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

PROTOCOL CODE: MYDARLD (IV Cycle 2+)

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).	
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, every 4 weeks, less than or equal to 7 days prior to the next cycle ☐ **HBV viral load** prior to next cycle ☐ **Other tests:** ☐ **Consults**: ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**