

**PROTOCOL CODE: MYDARLD (subcut)**

(Page 1 of 3)

Patient RevAid # \_\_\_\_\_

|   |  |  |
|---|--|--|
| <b>DOCTOR'S ORDERS</b>  |  | Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup> |
| <b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form   |  |  |
| <b>DATE:</b>  | <b>To be given:</b>  | <b>Cycle #:</b>  |
| Date of Previous Cycle: _____   |  |  |
| Risk Category: <input type="checkbox"/> <b>Female of Childbearing Potential (FCBP) Rx valid for 7 days</b>  |  |  |
| Risk Category: <input type="checkbox"/> <b>Male or Female of non-Childbearing Potential (NCBP)</b>  |  |  |
| **** <u>Ensure Red Blood Cell Phenotype and Group and Screen</u> for all patients prior to Cycle 1****  |  |  |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment <ul style="list-style-type: none"> <li>• May proceed with daratumumab day 1 doses as written, if within 96 hours (or within 48h on days 8,15, 22) <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, Platelets greater than or equal to 50 x 10<sup>9</sup>/L</b></li> <li>• May proceed with lenalidomide doses as written, if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, Platelets greater than or equal to 30 x 10<sup>9</sup>/L, eGFR as per protocol</b></li> </ul>   |  |  |
| Dose modification for: <input type="checkbox"/> <b>Hematology:</b> _____ <input type="checkbox"/> <b>Other Toxicity:</b> _____  |  |  |
| Proceed with treatment based on blood work from _____   |  |  |
| <b>CHEMOTHERAPY:</b><br><b>LENALIDOMIDE</b><br><input type="checkbox"/> lenalidomide* _____mg PO daily, in the evening, on days 1 to 21 and off for 7 days<br><br><input type="checkbox"/> lenalidomide* _____ mg PO _____<br><br>MITTE: (*available as 25 mg, 20mg, 15 mg, 10 mg, 5 mg and 2.5 mg capsules)<br>*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based<br><br><input type="checkbox"/> FCBP dispense 21 capsules (1 cycle)<br><input type="checkbox"/> For Male and Female NCBP:<br>Mitte: _____ capsules or _____ cycles. Maximum 63 capsules (3 cycles).<br>Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed<br><br><b>Physician to assure DVT prophylaxis in place: ASA, Warfarin, low molecular weight heparin or direct oral anticoagulant or none</b> | <u>Pharmacy Use for Lenalidomide:</u><br><br>RevAid confirmation number:<br>_____<br><br>Lenalidomide lot number:<br>_____<br><br>Pharmacist counsel (initial):<br>_____ |  |
| <b>DOCTOR'S SIGNATURE:</b>  | <b>SIGNATURE:</b>  |  |
| <b>Physician Revaid ID:</b>   | <b>UC:</b>   |  |

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(Page 2 of 3)

**DATE:**

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

Insert a peripheral IV and saline lock for Cycle 1 Day 1 only for use in the event of a hypersensitivity reaction.

**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 daratumumab on Cycle 1 Day 1

**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 # 1, Days 1, 8, 15 and 22:**

**daratumumab subcut 1800 mg** (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes\*

**CYCLE # 2, Days 1, 8, 15 and 22:**

**daratumumab subcut 1800 mg** (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes\*

**CYCLES 3 to 6, Days 1 and 15:**

**daratumumab subcut 1800 mg** (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes\*

x \_\_\_\_\_ **cycle(s)** (max 2 cycles)

**CYCLE 7 onwards, Day 1:**

**daratumumab subcut 1800 mg** (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes\*

x \_\_\_\_\_ **cycle(s)** (max 3 cycles)

\*Observe patient for 1 hour after administration on Day 1 of Cycle 1 only. For patients switching from IV daratumumab, observe for 30 minutes after the first subcutaneous dose. Observation not required on subsequent doses unless requested by physician. Vital signs immediately prior to and at the end of injection, and at end of observation period of first injection only, and as needed.

NB: During treatment with subcutaneous daratumumab, administer other subcutaneous drugs at alternative injection sites whenever possible

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(Page 3 of 3)

|  |                   |
|--|-------------------|
| <b>DATE:</b>   |                   |
| <b>RETURN APPOINTMENT ORDERS</b>   |                   |
| <p>For Cycles 1 and 2, book chemo on days 1, 8, 15 and 22<br/>         For Cycles 3 to 6, book chemo on days 1 and 15<br/>         For Cycle 7 onwards, book chemo on day 1</p> <p><input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____<br/> <input type="checkbox"/> Return in <b>eight</b> weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles.<br/> <input type="checkbox"/> Return in <b>twelve</b> weeks for Doctor and Cycles _____, _____ and _____. Book chemo x 3 cycles<br/> <input type="checkbox"/> Last Cycle. Return in _____ week(s).</p>   |                   |
| <p><b>Laboratory:</b> Blood work done prior to next cycle must be done less than or equal to 4 days prior to the start date<br/> <b>TSH every three months (i.e. prior to Cycles 4, 7, 10, 13, 16 etc)</b></p> <p><b><u>Prior to each cycle:</u></b><br/>         CBC &amp; Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin, Serum Protein Electrophoresis <b>and</b> Serum Free Light Chain Levels<br/>         If clinically indicated: <input type="checkbox"/> Immunoglobulin panel <input type="checkbox"/> Urine protein electrophoresis</p> <p><b><u>Cycles 1 and 2:</u></b><br/> <b>Day 8, 15, 22:</b> CBC &amp; Diff, platelets<br/> <input type="checkbox"/> CBC &amp; Diff, Platelets, Creatinine, Calcium every two weeks</p> <p><b><u>Cycles 3 and 4:</u></b><br/> <input type="checkbox"/> CBC &amp; Diff, Platelets, Creatinine, Calcium every two weeks</p> <p><b><u>Cycles 3 to 6:</u></b><br/> <b>Day 15:</b> CBC &amp; diff, platelets<br/>         If clinically indicated: <input type="checkbox"/> Sodium, Potassium <input type="checkbox"/> ALT <input type="checkbox"/> Bilirubin <input type="checkbox"/> Creatinine</p> <p><input type="checkbox"/> Quantitative beta- hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle<br/> <input type="checkbox"/> See general orders sheet for additional requests<br/> <input type="checkbox"/> Other tests:<br/> <input type="checkbox"/> Consults:</p> |                   |
| <b>DOCTOR'S SIGNATURE:</b>   | <b>SIGNATURE:</b> |
|  | <b>UC:</b>        |