PROTOCOL CODE: MYDARLD (subcut)

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** day of treatment

Proceed with all medications as written, if within 96 hours of Day 1: **ANC greater than or equal to 1.0 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:

DATE:

☐ **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 -

☐ **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:**

DATE:

****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

- 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 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

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

DATE:	
RETURN APPOINTMENT ORDERS	
For Cycles 1 and 2, book chemo on Days 1, 8, 15 and 22 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 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1 ☐ **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 ☐ **See general orders sheet for additional requests** ☐ **Other tests:** ☐ **Consults**:	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**