# PROTOCOL CODE: UMYDARLD (Cycle 2+)



**Patient RevAid #_____**

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

## 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 48h on days 8,15, 22) **ANC greater than or equal to 1 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 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 _____

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 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: UMYDARLD (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 10mg** PO prior to each daratumumab

**acetaminophen 650 mg** PO prior to each daratumumab. Repeat acetaminophen every 4 hours x 1 dose during infusion on day 1 of cycle 1 only, then every 4 hours when needed for fever

Select one of the following:

☐**diphenhydrAMINE 50 mg** ☐PO or ☐ IV prior to each daratumumab. Repeat **diphenhydramine 50 mg IV** every 4 hours when needed

***OR***

☐**loratadine 10mg** PO prior to each daratumumab, then **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)**

☐**CYCLE 7 onwards, Day 1:**

**daratumumab 16 mg/kg** x _____ kg = _____mg **IV in 500 mL NS (use 0.2 micron in-line filter)**

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

| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br>**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 _____

☐ 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 - 4:**

CBC & Diff, Platelets, Creatinine, Calcium every two weeks

**Cycles 3 - 6:**

**Day 1:** CBC & Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin.

**Day 1**: ☐Serum Protein Electrophoresis **and/or** ☐Serum Free Light Chain Levels (SELECT APPROPRIATE)

**Day 15:** CBC & diff, platelets

☐Sodium, Potassium

☐ALT

☐ bilirubin

☐Creatinine

**Cycle 7 onwards:**

**Day 1:** CBC & Diff, platelets, sodium, potassium, creatinine, calcium, ALT, bilirubin

**Day 1**: ☐Serum Protein Electrophoresis **and/or** ☐Serum Free Light Chain Levels (SELECT APPROPRIATE)

☐ 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:**<br><br>**UC:** |
|---|---|