

PROTOCOL CODE: MYDARLDF (subcut)

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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: <input type="checkbox"/> Female of Childbearing Potential (FCBP) Rx valid for 7 days		
Risk Category: <input type="checkbox"/> Male or Female of non-Childbearing Potential (NCBP)		
****Ensure Red Blood Cell Phenotype and Group and Screen for all patients prior to Cycle 1****		
<input type="checkbox"/> Delay treatment _____ week(s)		
<input type="checkbox"/> CBC & Diff, platelets day of treatment		
Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 50 x 10⁹/L, and eGFR or creatinine clearance as per protocol		
Dose modification for: <input type="checkbox"/> Hematology: _____ <input type="checkbox"/> Other Toxicity: _____		
Proceed with treatment based on blood work from _____		
<p>LENALIDOMIDE One cycle = 28 days</p> <ul style="list-style-type: none"> Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily <p><input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days</p> <p><input type="checkbox"/> lenalidomide* _____ mg PO _____</p> <p>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</p> <p><input type="checkbox"/> FCBP dispense 21 capsules (1 cycle) <input type="checkbox"/> For Male and Female NCBP:</p> <p>Mitte: _____ capsules or _____ cycles. Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed</p> <p>Physician to ensure DVT prophylaxis in place: <input type="checkbox"/> ASA, <input type="checkbox"/> Warfarin, <input type="checkbox"/> low molecular weight heparin, <input type="checkbox"/> direct oral anticoagulant or <input type="checkbox"/> none (select one)</p>	<p>Pharmacy Use for <u>Lenalidomide dispensing:</u> Part Fill # 1 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p> <p>Part Fill # 2 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p> <p>Part Fill # 3 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p>	
Special Instructions		
DOCTOR'S SIGNATURE:	SIGNATURE:	
Physician Revaid ID:	UC:	

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DATE:

- 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

****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

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DATE:	
RETURN APPOINTMENT ORDERS	
<p>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</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Return in eight weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles.</p> <p><input type="checkbox"/> Return in twelve weeks for Doctor and Cycles _____, _____ and _____. Book chemo x 3 cycles</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s).</p>	
<p>CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis <u>and</u> serum free light chain levels every 4 weeks</p> <p>TSH every three months (i.e. prior to Cycles 4, 7, 10, 13, 16 etc)</p> <p><input type="checkbox"/> Urine protein electrophoresis every 4 weeks</p> <p><input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks</p> <p><input type="checkbox"/> Beta-2 microglobulin every 4 weeks</p> <p><input type="checkbox"/> CBC & Diff, platelets Days 8, 15, 22</p> <p><input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22</p> <p><input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22</p> <p><input type="checkbox"/> Random glucose Days 8, 15, 22</p> <p><input type="checkbox"/> Calcium, albumin Days 8, 15, 22</p> <p><input type="checkbox"/> 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</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</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: