PROTOCOL CODE: MYDBLDFTE
Consolidation Phase (Cycles 5 and 6)

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)**

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** 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 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

- Ensure antiviral VZV prophylaxis is in place

☐ **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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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****

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm_____

- Ensure antiviral VZV prophylaxis is in place

If no reaction after 4 consecutive doses of daratumumab, may discontinue acetaminophen, loratadine/diphenhydrAMINE and montelukast

dexamethasone as ordered in steroid section prior to each daramumumab dose

☐ **montelukast 10 mg** PO prior to each daratumumab dose

acetaminophen 650 mg PO prior to each daratumumab dose

Select one of the following:

☐ **loratadine 10 mg** PO prior to each daratumumab dose

OR

☐ **diphenhydrAMINE 50 mg** ☐ PO or ☐ IV prior to each daratumumab dose

TREATMENT:

daratumumab subcut 1800 mg (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes on **Days 1 and 15**

bortezomib ☐ **1.5 mg/m²** or ☐ **1.3 mg/m²** or ☐ **1 mg/m²** or ☐ **0.7 mg/m²** or ☐ **0.5 mg/m²** (select one) x BSA =____ mg **subcutaneously** into abdomen or thigh on **Days 1, 8, 15, and 22**

NB: Ensure daratumumab and bortezomib injections are administered at well-separated sites and rotated between administrations.

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

PROTOCOL CODE: MYDBLDFTE
Consolidation Phase (Cycles 5 and 6)

DATE:	
RETURN APPOINTMENT ORDERS	
Cycles 5 and 6: book treatment on Days 1, 8, 15 and 22. ☐ Return in **four** weeks for Doctor and Cycle 6. ☐ Return in **four** weeks for Doctor and Cycle 7 (maintenance phase). Book treatment on Day 1.	
CBC & Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, serum protein electrophoresis *and* serum free light chain levels every 4 weeks **TSH prior to Cycle 7** ☐ **Urine protein electrophoresis** every 4 weeks ☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks ☐ **Urea, sodium, potassium** 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 ☐ **Calcium, albumin** Days 8, 15, 22 ☐ **Quantitative beta-hCG blood test for FCBP** 7-14 days and 24 h prior to Cycle 5 and every week for 4 weeks during Cycle 5 (i.e. the first Consolidation Phase cycle) ☐ **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:**