

**PROTOCOL CODE: MYDBLDFTE**  
**Induction Phase (Cycles 1 to 4)**

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

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<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***				
A referral to the Leukemia/BMT Program of BC must be made at the start of the first cycle or shortly after for planning purposes.				
<input type="checkbox"/> Delay treatment _____ week(s)				
<input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment				
Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: <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, and eGFR or creatinine clearance as per protocol</b>				
Dose modification for: <input type="checkbox"/> <b>Hematology:</b> _____ <input type="checkbox"/> <b>Other Toxicity:</b> _____				
Proceed with treatment based on blood work from _____				
<p><b>LENALIDOMIDE</b> One cycle = 28 days</p> <ul style="list-style-type: none"> <li>Ensure antiviral VZV prophylaxis is in place</li> </ul> <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)</p> <p><input type="checkbox"/> For Male and Female NCBP:</p> <p>Mitte: _____ capsules or _____ cycles. Maximum 63 capsules (3 cycles).</p> <p>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><b>Pharmacy Use for</b> <u>Lenalidomide dispensing:</u></p> <p>Part Fill # 1 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p> <p>Part Fill # 2 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p> <p>Part Fill # 3 RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>	
<b>Special Instructions</b>				
<b>DOCTOR'S SIGNATURE:</b>			<b>SIGNATURE:</b>	
<b>Physician RevaId ID:</b>			<b>UC:</b>	

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**DATE:**

**STERIOD (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 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

**montelukast 10 mg** PO prior to daratumumab on Cycle 1 Day 1

**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:**

**CYCLES 1 and 2:**

**daratumumab subcut 1800 mg** (fixed dose in 15 mL) **subcutaneously** into abdomen over 5 minutes\* on **Days 1, 8, 15 and 22**

**bortezomib**  **1.5 mg/m<sup>2</sup>** or  **1.3 mg/m<sup>2</sup>** or  **1 mg/m<sup>2</sup>** or  **0.7 mg/m<sup>2</sup>** or  **0.5 mg/m<sup>2</sup>** (select one) x BSA = \_\_\_\_\_ mg **subcutaneously** into abdomen or thigh on **Days 1, 8, 15, and 22**

**CYCLES 3 and 4:**

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

**bortezomib**  **1.5 mg/m<sup>2</sup>** or  **1.3 mg/m<sup>2</sup>** or  **1 mg/m<sup>2</sup>** or  **0.7 mg/m<sup>2</sup>** or  **0.5 mg/m<sup>2</sup>** (select one) x BSA = \_\_\_\_\_ mg **subcutaneously** into abdomen or thigh on **Days 1, 8, 15, and 22**

\*Observe patient for 1 hour after administration on Day 1 of Cycle 1 only. Observation not required on subsequent doses unless requested by physician. Vital signs immediately prior to and at the end of injection, at end of observation period of first injection only, and as needed.

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

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____. Book treatment on Days 1, 8, 15 and 22. <input type="checkbox"/> Return in _____ week(s) for pre-transplant assessment <input type="checkbox"/> Return in _____ week(s) for _____	
<p><b>CBC &amp; Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, serum protein electrophoresis <u>and</u> serum free light chain levels every 4 weeks</b></p> <p><b>TSH prior to Cycle 4</b></p> <input type="checkbox"/> Urine protein electrophoresis every 4 weeks <input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks <input type="checkbox"/> Urea, sodium, potassium every 4 weeks <input type="checkbox"/> CBC & Diff Days 8, 15, 22 <input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22 <input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22 <input type="checkbox"/> Calcium, albumin Days 8, 15, 22 <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 <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 <input type="checkbox"/> HBV viral load prior to next cycle <input type="checkbox"/> See general orders sheet for additional requests <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults:	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>