BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: MYDBLDFTE
Maintenance Phase (Cycle 7 and onward)

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 28 continuously

☐ **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:

****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 premedications

☐ **dexamethasone 20 mg** PO prior to each daratumumab 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 **Day 1**

x ____ cycle(s) (max 3 cycles)

NB: During treatment with subcutaneous daratumumab, administer other subcutaneous drugs at alternative injection sites whenever possible

RETURN APPOINTMENT ORDERS

☐ Return in **<u>four</u>** weeks for Doctor and Cycle ______.
☐ Return in **<u>eight</u>** weeks for Doctor and Cycles ______ and ______. Book chemo x 2 cycles.
☐ Return in **<u>twelve</u>** weeks for Doctor and Cycles ________, ________ and ________. Book chemo x 3 cycles
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, creatinine, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, serum protein electrophoresis *<u>and</u>* serum free light chain levels every 4 weeks

TSH every 3 months

☐ **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**, 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: