

**PROTOCOL CODE: MYDBLDFTE**  
**Maintenance Phase**  
**(Daratumumab Restart, if needed)**

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

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<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>		
<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 _____		
<b>LENALIDOMIDE</b> <b>One cycle = 28 days</b> <ul style="list-style-type: none"> <li>• Ensure antiviral VZV prophylaxis is in place</li> </ul> <input type="checkbox"/> <b>lenalidomide*</b> _____ mg PO daily, in the evening, on Days 1 to 28 continuously <input type="checkbox"/> <b>lenalidomide*</b> _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days <input type="checkbox"/> <b>lenalidomide*</b> _____ 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  <input type="checkbox"/> FCBP dispense 21 capsules (1 cycle) <input type="checkbox"/> 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  <b>Physician to ensure DVT prophylaxis in place:</b> <input type="checkbox"/> <b>ASA</b> , <input type="checkbox"/> <b>Warfarin</b> , <input type="checkbox"/> <b>low molecular weight heparin</b> , <input type="checkbox"/> <b>direct oral anticoagulant</b> or <input type="checkbox"/> <b>none</b> (select one)	<b>Pharmacy Use for</b> <b>Lenalidomide dispensing:</b> <b>Part Fill # 1</b> RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____ <b>Part Fill # 2</b> RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____ <b>Part Fill # 3</b> RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____	
<b>Special Instructions</b>		
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>	
<b>Physician Revaid ID:</b>	<b>UC:</b>	

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<b>DATE:</b>	
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b> Insert a peripheral IV and saline lock for Cycle 1 Day 1 only for use in the event of a hypersensitivity reaction.	
<b>DARATUMUMAB PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____	
<ul style="list-style-type: none"> <li>• Ensure antiviral VZV prophylaxis is in place</li> </ul>	
If no reaction after 4 consecutive doses of daratumumab, may discontinue premedications	
<b>dexamethasone</b> <input type="checkbox"/> 20 mg or <input type="checkbox"/> 40 mg (select one) prior to each daratumumab dose on Cycle 1 Days 1, 8, 15 and 22 <input type="checkbox"/> dexamethasone <input type="checkbox"/> 20 mg or <input type="checkbox"/> 40 mg (select one) prior to each daratumumab dose in Cycle 2 and onward	
<b>montelukast 10 mg PO</b> prior to daratumumab on Cycle 1 Day 1 <input type="checkbox"/> montelukast 10 mg PO prior to each daratumumab dose	
<b>acetaminophen 650 mg PO</b> prior to each daratumumab dose	
Select one of the following:	
<input type="checkbox"/> loratadine 10 mg PO prior to each daratumumab dose	
<b>OR</b>	
<input type="checkbox"/> diphenhydramine 50 mg <input type="checkbox"/> PO or <input type="checkbox"/> IV prior to each daratumumab dose	
<b>DARATUMUMAB</b>	
<input type="checkbox"/> <b>CYCLE # 1 and 2, Days 1, 8, 15 and 22:</b> <b>daratumumab subcut 1800 mg</b> (fixed dose in 15 mL) <b>subcutaneously</b> into abdomen over 5 minutes*	
<input type="checkbox"/> <b>CYCLES 3 to 6, Days 1 and 15:</b> <b>daratumumab subcut 1800 mg</b> (fixed dose in 15 mL) <b>subcutaneously</b> into abdomen over 5 minutes* <span style="float: right;">x ____ cycle(s) (max 2 cycles)</span>	
<input type="checkbox"/> <b>CYCLE 7 onwards, Day 1:</b> <b>daratumumab subcut 1800 mg</b> (fixed dose in 15 mL) <b>subcutaneously</b> into abdomen over 5 minutes* <span style="float: right;">x ____ cycle(s) (max 3 cycles)</span>	
<small>*Observe patient for 1 hour after administration on Day 1 of Restart Cycle 1 only. 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.</small>	
<small>NB: During treatment with subcutaneous daratumumab, administer other subcutaneous drugs at alternative injection sites whenever possible</small>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<p>For Cycles 1 and 2, book treatment on Days 1, 8, 15 and 22          For Cycles 3 to 6, book treatment on Days 1 and 15          For Cycle 7 onwards, book treatment on Day 1</p> <p><input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Return in <b>eight</b> weeks for Doctor and Cycles _____ and _____. Book treatment x 2 cycles.</p> <p><input type="checkbox"/> Return in <b>twelve</b> weeks for Doctor and Cycles _____, _____ and _____. Book treatment x 3 cycles.</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s).</p>	
<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</b> every 4 weeks</p> <p><b>TSH</b> every three months</p> <p><input type="checkbox"/> <b>urine protein electrophoresis</b> every 4 weeks</p> <p><input type="checkbox"/> <b>immunoglobulin panel (IgA, IgG, IgM)</b> every 4 weeks</p> <p><input type="checkbox"/> <b>urea, sodium, potassium</b> every 4 weeks</p> <p><input type="checkbox"/> <b>CBC &amp; Diff</b> Days 8, 15, 22</p> <p><input type="checkbox"/> <b>creatinine, sodium, potassium</b> Days 8, 15, 22</p> <p><input type="checkbox"/> <b>total bilirubin, ALT, alkaline phosphatase</b> Days 8, 15, 22</p> <p><input type="checkbox"/> <b>calcium, albumin</b> Days 8, 15, 22</p> <p><input type="checkbox"/> <b>Quantitative beta- hCG blood test for FCBP</b>, every 4 weeks, less than or equal to 7 days prior to the next cycle</p> <p><input type="checkbox"/> <b>HBV viral load</b> prior to next cycle</p> <p><input type="checkbox"/> <b>See general orders sheet for additional requests</b></p> <p><input type="checkbox"/> <b>Other tests:</b></p> <p><input type="checkbox"/> <b>Consults:</b></p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>