PROTOCOL CODE: MYDBLDFTI

Cycle 9 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)**

****Ensure Red Blood Cell Phenotype **and Group and Screen** for all patients prior to Cycle 1****

☐ 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 _____

(*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:
Dispense: _____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:

PROTOCOL CODE: MYDBLDFTI

Cycle 9 and onward

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****

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 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

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

PROTOCOL CODE: MYDBLDFTI

Cycle 9 and onward

DATE:

RETURN APPOINTMENT ORDERS

- ☐ Return in **four** weeks for Doctor and Cycle _____. Book treatment on Day 1.
- ☐ Return in **eight** weeks for Doctor and Cycles _____ Book treatment x 2 cycles (on Day 1).
- ☐ Return in **twelve** weeks for Doctor and Cycles _____ Book treatment x 3 cycles (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 every 3 months (i.e. prior to Cycles 10, 13, 16 etc)

- ☐ **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 1 and every week for 4 weeks during Cycle 1
- ☐ **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: