

**PROTOCOL CODE: MYDBLDF**  
**Maintenance Phase (Cycle 7 and onward)**

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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>		
<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"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 28 continuously <input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days <input type="checkbox"/> lenalidomide* _____ mg PO _____	<b>Pharmacy Use for</b> <b>Lenalidomide dispensing:</b> <b>Part Fill # 1</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____ <b>Part Fill # 2</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____ <b>Part Fill # 3</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____	
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"/> 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)		
<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>	
<b>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> <p>If no reaction after 4 consecutive doses of daratumumab, may discontinue premedications</p> <p><input type="checkbox"/> dexamethasone 20 mg PO prior to each daratumumab dose</p> <p><input type="checkbox"/> montelukast 10 mg PO prior to each daratumumab dose</p> <p><b>acetaminophen 650 mg PO prior to each daratumumab dose</b></p> <p>Select one of the following:</p> <p><input type="checkbox"/> loratadine 10 mg PO prior to each daratumumab dose</p> <p><b>OR</b></p> <p><input type="checkbox"/> diphenhydrAMINE 50 mg <input type="checkbox"/> PO or <input type="checkbox"/> IV prior to each daratumumab dose</p>	
<b>TREATMENT:</b>	
<p><b>daratumumab subcut 1800 mg (fixed dose in 15 mL) subcutaneously into abdomen over 5 minutes on Day 1</b></p> <p style="text-align: right;"><b>x ____ cycle(s) (max 3 cycles)</b></p> <p>NB: During treatment with subcutaneous daratumumab, administer other subcutaneous drugs at alternative injection sites whenever possible</p>	
<b>RETURN APPOINTMENT ORDERS</b>	
<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 chemo x 2 cycles.</p> <p><input type="checkbox"/> Return in <b>twelve</b> weeks for Doctor and Cycles _____, _____ and _____. Book chemo 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 every 4 weeks</b></p> <p><b>TSH every 3 months</b></p> <p><input type="checkbox"/> Urine protein electrophoresis every 4 weeks</p> <p><input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks</p> <p><input type="checkbox"/> Urea, sodium, potassium every 4 weeks</p> <p><input type="checkbox"/> CBC &amp; Diff Days 8, 15, 22</p> <p><input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22</p> <p><input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22</p> <p><input type="checkbox"/> Calcium, albumin Days 8, 15, 22</p> <p><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</p> <p><input type="checkbox"/> HBV viral load prior to next cycle</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p> <p><input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Consults: _____</p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>