

**PROTOCOL CODE: MYDBLDF (subcut)
Consolidation Phase (Cycles 5 and 6)**

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Patient RevAid # _____

DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²
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: <input type="checkbox"/> Female of Childbearing Potential (FCBP) Rx valid for 7 days		
Risk Category: <input type="checkbox"/> Male or Female of non-Childbearing Potential (NCBP)		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> 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 10⁹/L, platelets greater than or equal to 50 x 10⁹/L, and eGFR or creatinine clearance as per protocol Dose modification for: <input type="checkbox"/> Hematology: _____ <input type="checkbox"/> Other Toxicity: _____ Proceed with treatment based on blood work from _____		
LENALIDOMIDE One cycle = 28 days <ul style="list-style-type: none"> • Ensure antiviral VZV prophylaxis is in place <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 _____ 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 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)	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:	SIGNATURE:	
Physician Revaid ID:	UC:	

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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****

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 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 **Days 1 and 15**

bortezomib **1.5 mg/m²** or **1.3 mg/m²** or **1 mg/m²** or **0.7 mg/m²** or **0.5 mg/m²** (select one) x BSA = _____ mg **subcutaneously** into abdomen or thigh on **Days 1, 8, 15, and 22**

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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DATE:	
RETURN APPOINTMENT ORDERS	
<p>Cycles 5 and 6: book treatment on Days 1, 8, 15 and 22.</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle 6.</p> <p><input type="checkbox"/> Return in four weeks for Doctor and Cycle 7 (maintenance phase). Book treatment on Day 1.</p>	
<p>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</p> <p>TSH prior to Cycle 7</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 & 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 7-14 days and 24 h prior to Cycle 5 and every week for 4 weeks during Cycle 5 (i.e. the first Consolidation Phase cycle)</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:</p> <p><input type="checkbox"/> Consults:</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: