

**PROTOCOL CODE: ULYOGGEOX**  
**Cycles 9 to 12**

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

<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: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment					
May proceed with doses as written if within 48 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 75 x 10<sup>9</sup>/L</b>					
Dose modification for: <input type="checkbox"/> Other Toxicity: _____ Proceed with treatment based on blood work from _____					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.					
Ensure antiviral and antimicrobial prophylaxis is in place					
Optional if CRS with previous dose:					
<input type="checkbox"/> 60 minutes prior to treatment: <b>dexamethasone 20 mg IV</b>					
30 minutes prior to treatment:					
<b>acetaminophen 650 to 975 mg PO</b>					
<b>diphenhydrAMINE 50 mg</b> <input type="checkbox"/> PO or <input type="checkbox"/> IV (select one)					
<input type="checkbox"/> <b>Other:</b> _____					
<b>PREHYDRATION:</b>					
<input type="checkbox"/> 500 mL NS IV over 30 minutes prior to glofitamab					
<b>** Have Hypersensitivity Reaction Tray and Protocol Available**</b>					
<b>TREATMENT:</b>					
<b>glofitamab 30 mg IV</b> in 100 mL NS over 2 hours					
Vital signs prior to glofitamab, at the end of the infusion, and as clinically indicated.					
<b>DOCTOR'S SIGNATURE:</b>					<b>SIGNATURE:</b>
					<b>UC:</b>

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book treatment on Day 1. <input type="checkbox"/> Last cycle. Return in _____ week(s).	
<b>CBC &amp; Diff, creatinine, total bilirubin, ALT</b> prior to each cycle  If clinically indicated: <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> phosphate <input type="checkbox"/> calcium <input type="checkbox"/> magnesium <input type="checkbox"/> uric acid <input type="checkbox"/> albumin <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> GGT <input type="checkbox"/> LDH <input type="checkbox"/> random glucose <input type="checkbox"/> immunoglobulin panel (IgA, IgG, IgM) <input type="checkbox"/> HBV viral load every 3 months <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b> <b>UC:</b>