

**daratumumab-hyaluronidase
1800 mg -
cyclophosphamide 300 -
bortezomib 1.5 -**

dexamethasone 40 mg Regimen: Cycles 9+

ARIA Protocol Name: Daratumumab SC CyBorD

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4350 0245 08 2022

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____

Cycle Duration: **28 days**

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- 60 minutes prior to daratumumab-hyaluronidase: dexamethasone 20 mg PO** on day 1
- 60 minutes prior to daratumumab-hyaluronidase: diphenhydrAMINE 50 mg PO** on day 1
- 60 minutes prior to daratumumab-hyaluronidase: acetaminophen 650 mg PO** on day 1
- Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- acyclovir 800 mg PO** once daily until one month post completion of daratumumab treatment
- Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- daratumumab-hyaluronidase 1800 mg**
SC on day 1 (Administer over 3 to 5 minutes into abdomen)
- First injection: Observe patient for 4 hours after daratumumab-hyaluronidase SC injection
- Subsequent injections: If no reaction in previous injection, observe patient for 15 to 20 minutes after daratumumab-hyaluronidase SC injection

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.