CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab-hyaluronidase 1800 mg - cyclophosphamide 300 - bortezomib 1.5 - dexamethasone 20 mg Regimen: Cycles 9+

ARIA Protocol Name: Daratumumab SC CyBorD (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4190 0230 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 X 10^9/L and platelets **greater than or equal to** 50 X 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.