



Doctor's Order Sheet

**daratumumab-hyaluronidase  
1800 mg -  
cyclophosphamide 300 -  
bortezomib 1.5 -  
dexamethasone 20 mg**

Regimen: Cycles 3-6 (Part I)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC4220 0233 08 2022

**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**  $80 \times 10^9/L$ , otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

**PREMEDICATIONS (FOR HOSPITAL PHARMACY):**

- 60 minutes prior to daratumumab-hyaluronidase: diphenhydramine 50 mg PO** on day 1 and 15
- 60 minutes prior to daratumumab-hyaluronidase: acetaminophen 650 mg PO** on day 1 and 15
- Other: \_\_\_\_\_

**HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):**

- acyclovir 800 mg PO** once daily until one month post completion of daratumumab/bortezomib treatment
- metoclopramide 10-20 mg PO** every 4 hours as needed
- Other: \_\_\_\_\_

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.



Doctor's Order Sheet

**daratumumab-hyaluronidase  
1800 mg -  
cyclophosphamide 300 -  
bortezomib 1.5 -  
dexamethasone 20 mg**

Regimen: Cycles 3-6 (Part II)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



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Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ cm Body Surface Area (BSA) = \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**bortezomib 1.5 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**

Dose modification: **bortezomib 1.5 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**

**SC** on day 1, 8, 15 and 22

**daratumumab-hyaluronidase 1800 mg**

**SC** on day 1 and 15

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

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

**dexamethasone 20 mg PO** once daily in the morning on day 1, 8, 15 and 22 (60 minutes pre daratumumab-hyaluronidase on day 1 and 15)

**cyclophosphamide 300 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**

Dose modification: **cyclophosphamide 300 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**

**PO** on day 1, 8, 15 and 22

This prescription is NOT eligible for medication management by a pharmacist

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: \_\_\_\_\_

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