CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab 16 mg/kg - cyclophosphamide 300 - bortezomib 1.5 - dexamethasone 20 mg

Regimen: Cycles 9+ (Part I)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4590 0269 09 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 X 10^9/L and platelets **greater than or equal to** 80 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: dexamethasone 20 mg PO** on day 1

☐ **60 minutes prior to daratumumab: diphenhydrAMINE 50 mg PO** on day 1

☐ **60 minutes prior to daratumumab: 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/bortezomib treatment

☐ 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.

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Doctor's Order Sheet

daratumumab 16 mg/kg - cyclophosphamide 300 - bortezomib 1.5 - dexamethasone 20 mg

Regimen: Cycles 9+ (Part II)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4590 0269 09 2022

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **daratumumab 16 mg/kg** X weight (kg) **=** _____ **mg**

☐ Dose modification: **daratumumab 16 mg/kg** X weight (kg) - _____% =_____ **mg**

IV in 500 mL normal saline on day 1 (1000 mL if infusion reaction during last daratumumab infusion)

Observe patient for 30 minutes after infusion (observation not required after 3 treatments with no reaction)

If no reaction in the previous infusion or reaction is Grade 2 or less: Start infusion at 200 mL/hr. If no reaction after 30 minutes, infuse the remainder at 450 mL/hr

If reaction in the previous infusion is Grade 3: Start infusion at 100 mL/hr. If no reactions after 60 minutes, increase by 50 mL/hr every 60 minutes until maximum of 200 mL/hr

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: _____