CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Doctor's Order Sheet

belantamab mafodotin 2.5 mg/kg Regimen

ARIA Protocol Name: Belantamab mafodotin-blmf Special Access MM

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4610 0271 01 2023

Name:

HCN:

Date of Birth:

Weight: _________kg Height:__________________________cm Body Surface Area (BSA) = ______________

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY ________________ Planned Administration Date: DD/MONTH/YYYY ________

Cycle_______ of _______ **Cycle Duration: 21 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** 75 X 10^9/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed.
- Ocular examination assessed (cycles 1 to 4 and when clinically indicated)

PREMEDICATIONS:

☐ Other: ____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **belantamab mafodotin 2.5 mg/kg** X weight (kg) **=** ____________ **mg**

☐ Dose modification: **belantamab mafodotin 1.9 mg/kg** X weight (kg) =_________ **mg**

IV in 250 mL normal saline over 30 minutes on day 1

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **preservative-free artificial tears topically** to both eyes 4 to 8 times a day continuously

☐ 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.

CP-0271 2023/01