

daratumumab 16 mg/kg Regimen

ARIA Protocol Name: Daratumumab IV Maintenance

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4670 0277 07 2022

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

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.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

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

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 the 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

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- acyclovir 800 mg PO** once daily until 4 weeks post completion of daratumumab 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: _____

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