

**daratumumab 16 mg/kg -
bortezomib 1.3 -
dexamethasone 20 mg**

Regimen: Cycles 4-8 (Part I)

ARIA Protocol Name: Dara IV Bortez Dex (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4380 0248 07 2022

Name: _____

HCN: _____

Date of Birth: _____

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** $1 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

60 minutes prior to daratumumab: acetaminophen 650 mg PO on day 1

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

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

acyclovir 800 mg PO once daily until 4 weeks 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: _____

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Doctor's Order Sheet
**daratumumab 16 mg/kg -
bortezomib 1.3 -
dexamethasone 20 mg**

Regimen: Cycles 4-8 (Part II)
ARIA Protocol Name: Dara IV Bortez Dex (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 1.3 mg/m² X BSA = _____ mg

Dose modification: **bortezomib 1.3 mg/m² X BSA - _____ % = _____ mg**

SC on day 1, 8, and 15

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

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 20 mg PO on day 1, 8 and 15

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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