CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab 16 mg/kg - lenalidomide 25 mg - dexamethasone 40 mg

Regimen: Cycle 2 (Part I)

ARIA Protocol Name: Dara IV Len Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4690 0279 07 2022

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 X 10^9/L and platelets **greater than or equal to** 50 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **60 minutes prior to daratumumab: acetaminophen 650 mg PO** on day 1, 8, 15 and 22

☐ **60 minutes prior to daratumumab: diphenhydrAMINE 50 mg PO** on day 1, 8, 15 and 22

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **acetylsalicylic acid 81 mg PO** once daily continuously while taking lenalidomide

☐**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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CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab 16 mg/kg - lenalidomide 25 mg - dexamethasone 40 mg

Regimen: Cycle 2 (Part II)

ARIA Protocol Name: Dara IV Len Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4690 0279 07 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, 8, 15 and 22 (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

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg PO** on day 1, 8, 15 and 22

☐ **lenalidomide 25 mg PO** once daily on days 1 to 21 (ensure patient enrolled in managed access program)

- ☐ Dose modification: **lenalidomide 20 mg PO** once daily on days 1 to 21
- ☐ Dose modification: **lenalidomide 15 mg PO** once daily on days 1 to 21
- ☐ Dose modification: **lenalidomide 10 mg PO** once daily on days 1 to 21
- ☐ Dose modification: **lenalidomide 15 mg PO** every other day on days 1 to 21
- ☐ Dose modification: **lenalidomide 5 mg PO** once daily on days 1 to 21
- ☐ Dose modification: **lenalidomide 2.5 mg PO** once daily on days 1 to 21

This prescription is NOT eligible for pharmacist prescribing by dispensing 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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