CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

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

Regimen: Cycles 7+ (Part I)

ARIA Protocol Name: Dara IV Len Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC4710 0281 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

☐ **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):

☐ **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: Cycles 7+ (Part II)

ARIA Protocol Name: Dara IV Len Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4710 0281 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 (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 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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