

**daratumumab 16 mg/kg -
lenalidomide 25 mg -
dexamethasone 20 mg**

Regimen: Cycle 2 (Part I)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC5850 0395 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** $1 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

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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Doctor's Order Sheet
**daratumumab 16 mg/kg -
lenalidomide 25 mg -
dexamethasone 20 mg**

Regimen: Cycle 2 (Part II)
ARIA Protocol Name: Dara IV Len Dex (age and comorbidities)
Adult Chemotherapy - Hematology Oncology
Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC5850 0395 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 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, 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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