

**daratumumab-hyaluronidase
1800 mg -
lenalidomide 25 mg -
dexamethasone 40 mg**

Regimen: Cycles 7+ (Part I)
ARIA Protocol Name: Dara SC Len Dex
Adult Chemotherapy - Hematology Oncology
Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC5780 0388 08 2023

Allergies:		<input type="checkbox"/> No Known
Date: <u>DD/MONTH/YYYY</u>	Planned Administration Date: <u>DD/MONTH/YYYY</u>	
Cycle <u> </u> of <u> </u>	Cycle Duration: 28 days	Date of previous cycle: <u>DD/MONTH/YYYY</u>
MAY PROCEED WITH DOSES AS WRITTEN IF:		
<ul style="list-style-type: none"> • ANC greater than or equal to 1 X 10⁹/L and platelets greater than or equal to 50 X 10⁹/L, otherwise notify Hematologist. • LFTs and Bilirubin assessed. • Creatinine clearance assessed. 		
PREMEDICATIONS (FOR HOSPITAL PHARMACY):		
<input type="checkbox"/> 60 minutes prior to daratumumab-hyaluronidase: acetaminophen 650 mg PO on day 1		
<input type="checkbox"/> 60 minutes prior to daratumumab-hyaluronidase: diphenhydrAMINE 50 mg PO on day 1		
<input type="checkbox"/> Other: _____		
HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):		
<input type="checkbox"/> acetylsalicylic acid 81 mg PO once daily		
<input type="checkbox"/> acyclovir 800 mg PO once daily until 4 weeks post completion of daratumumab treatment		
<input type="checkbox"/> metoclopramide 10-20 mg PO every 4 hours as needed		
<input type="checkbox"/> 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.



Doctor's Order Sheet

daratumumab-hyaluronidase

1800 mg -

lenalidomide 25 mg -

dexamethasone 40 mg Regimen: Cycles 7+ (Part II)

ARIA Protocol Name: Dara SC Len Dex

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):

daratumumab-hyaluronidase 1800 mg

SC on day 1

Administer over 3 to 5 minutes into abdomen

First injection: Observe patient for 4 hours after daratumumab-hyaluronidase SC injection

Subsequent injections: If no reaction in previous injection, observe patient for 15 to 20 minutes after daratumumab-hyaluronidase SC injection

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 40 mg PO on day 1, 8, 15 and 22 (60 minutes pre daratumumab-hyaluronidase on day 1)

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

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Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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