CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab-hyaluronidase 1800 mg - cyclophosphamide 300 - bortezomib 1.3 - dexamethasone 20 mg

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Dara SC CyBorD Amyloidosis (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC6350 0445 01 2024

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** 0.5 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.
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **60 minutes prior to daratumumab-hyaluronidase: dexamethasone 20 mg PO** on day 1

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

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

☐ **60 minutes prior to daratumumab-hyaluronidase: montelukast 10 mg PO** on day 1

☐ Other: ____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **diphenhydrAMINE 50 mg IV** every 4 hours PRN on day 1, 8, 15 and 22

☐ **acetaminophen 650 mg PO** every 4 hours PRN on day 1, 8, 15 and 22

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐**acyclovir 800 mg PO** daily until one month post completion of daratumumab/bortezomib treatment

☐ **metoclopramide 10-20 mg PO** every 4 hours PRN

☐ 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.

Cancer Care Program

Doctor's Order Sheet

daratumumab-hyaluronidase 1800 mg - cyclophosphamide 300 - bortezomib 1.3 - dexamethasone 20 mg

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Dara SC CyBorD Amyloidosis (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC6350 0445 01 2024

Weight: ___________kg Height:____________________cm Body Surface Area (BSA) = __________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **cyclophosphamide 300 mg/m²** X BSA **=** ___________ **mg** (cap dose at 500 mg)

☐ Dose modification: **cyclophosphamide 300 mg/m²** X BSA - _________% =_________ **mg** (cap dose at 500 mg)

PO on day 1

☐ **bortezomib 1.3 mg/m²** X BSA **=** ___________ **mg**

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

SC on day 1, 8, 15 and 22

☐ **daratumumab-hyaluronidase 1800 mg**

SC on day 1, 8, 15 and 22

Administer over 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 20 mg**

PO 60 minutes pre daratumumab-hyaluronidase on day 8, 15 and 22

☐ **cyclophosphamide 300 mg/m²** X BSA **=** ___________ **mg** (cap dose at 500 mg)

☐ Dose modification: **cyclophosphamide 300 mg/m²** X BSA - _________% =_________ **mg** (cap dose at 500 mg)

PO on day 8, 15 and 22

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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