

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

Regimen: Cycles 3-6 (Part I)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC6370 0447 01 2024

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** 0.5 X 10⁹/L and platelets **greater than or equal to** 50 X 10⁹/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- 60 minutes prior to daratumumab-hyaluronidase: diphenhydrAMINE 50 mg PO/IV** on day 1 and 15
- 60 minutes prior to daratumumab-hyaluronidase: acetaminophen 650 mg PO** on day 1 and 15
- Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

- diphenhydrAMINE 50 mg IV** every 4 hours PRN on day 1 and 15
- acetaminophen 650 mg PO** every 4 hours PRN on day 1 and 15
- Other: _____

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: _____

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Doctor's Order Sheet

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

Regimen: Cycles 3-6 (Part II)

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

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

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 and 15

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 in the morning on day 1, 8, 15 and 22 (pre daratumumab-hyaluronidase on day 1 and 15)

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, 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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