



Doctor's Order Sheet

glofitamab 30 mg

Regimen: Cycles 2 and 3

ARIA Protocol Name: glofitamab

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Diffuse Large B-Cell Lymphoma (DLBCL), DLBCL transformed from indolent lymphoma, high grade B-cell lymphoma (HGBCL), primary mediastinal B-cell lymphoma (PMBCL) or follicular lymphoma Grade 3B (FLG3b)



CC6950 0515 10/2024

Name: _____

HCN: _____

Date of Birth: _____

Cancer Care Program

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle of

Cycle Duration: **21 days**

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $0.5 \times 10^9/L$ 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 glofitamab: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1
- 30 minutes prior to glofitamab: acetaminophen 1000 mg PO** on day 1
- 30 minutes prior to glofitamab: diphenhydrAMINE 50 mg PO** on day 1
- Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- glofitamab 30 mg**
IV in 70 mL normal saline over 4 hours on day 1. May reduce infusion time to 2 hours for cycle 3 if previous dose tolerated well.

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- sulfamethoxazole/trimethoprim 400/80 mg PO** once daily for duration of treatment
- valacyclovir 500 mg PO** twice daily for duration of 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: _____

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