

Doctor's Order Sheet

**teclistamab 1.5 mg/kg**

Regimen: Cycles 4+ (Part I)

**ARIA Protocol Name:** teclistamab Cycles 4+ q2weeks - Compassionate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma



CC6890 0509 09/2024

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**  $0.5 \times 10^9/L$  and platelets **greater than or equal to**  $25 \times 10^9/L$ , otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

**PREMEDICATIONS (FOR HOSPITAL PHARMACY):**

- 60 minutes prior to teclistamab: dexamethasone 16 mg IV** in 50 mL normal saline over 15 minutes on days 1 and 15
- 60 minutes prior to teclistamab: acetaminophen 1000 mg PO** on days 1 and 15.
- 60 minutes prior to teclistamab: diphenhydrAMINE 50 mg IV** in 50 mL normal saline over 15 minutes on days 1 and 15.
- Other: \_\_\_\_\_

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_ 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

**teclistamab 1.5 mg/kg**

Regimen: Cycles 4+ (Part II)

**ARIA Protocol Name:** teclistamab Cycles 4+ q2weeks - Compassionate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma



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

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**teclistamab 1.5 mg/kg X weight (kg)= \_\_\_\_\_ mg SUBCUTANEOUS** on days 1 and 15

**HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):**

**acyclovir 800 mg PO** once daily for duration of treatment

**sulfamethoxazole/trimethoprim 400/80 mg PO** once 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: \_\_\_\_\_

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Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_