CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

epcoritamab 48 mg

Regimen: Cycles 4-9

ARIA Protocol Name: epcoritamab

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)

CC6980 0518 10/2024

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.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **diphenhydrAMINE 50 mg PO** pre epcoritamab on days 1 and 15

☐ **acetaminophen 650 mg PO** pre epcoritamab on days 1 and 15

☐ **dexamethasone 16 mg PO** pre epcoritamab on days 1 and 15

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **epcoritamab 48 mg SUBCUTANEOUS** on days 1 and 15

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.