CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

mirvetuximab soravtansine 6 mg/kg

Regimen (Part I)

ARIA Protocol Name: mirvetuximab Compassionate

Adult Chemotherapy - Gynecologic Oncology

Platinum Resistant Ovarian Carcinoma

CC7110 0531 01 2025

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** 1 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Ophthalmic exams completed as per recommendations
- Neuropathy assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **30 minutes pre chemo: dexamethasone 10 mg IV** in 50 mL normal saline over 15 minutes on day 1

☐ **30 minutes pre chemo: diphenhydrAMINE 50 mg PO** on day 1

☐ **30 minutes pre chemo: acetaminophen 650 mg PO** on day 1

☐ **30 minutes pre chemo: ondansetron 8 mg PO** on day 1

☐ 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

mirvetuximab soravtansine 6 mg/kg

Regimen (Part II)

ARIA Protocol Name: mirvetuximab Compassionate

Adult Chemotherapy - Gynecologic Oncology

Platinum Resistant Ovarian Carcinoma

CC7110 0531 01 2025

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **mirvetuximab soravtansine 6 mg/kg** X AIBW (adjusted ideal body weight**) =** _____ **mg**

☐ Dose modification: **mirvetuximab soravtansine 6 mg/kg** - _____% =_____ **mg**

IV in D5W PVC free to a final concentration of 1 to 2 mg/mL on day 1

Administer the initial dose as an intravenous infusion at the rate of 1 mg/min. If well tolerated after 30 minutes at 1 mg/min, the infusion rate can be increased to 3 mg/min. If well tolerated after 30 minutes at 3 mg/min, the infusion rate can be increased to 5 mg/min.

If no infusion-related reactions occur with the previous dose, subsequent infusions should be started at the maximally tolerated rate and may be increased up to a maximum infusion rate of 5 mg/min, as tolerated.

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **Refresh Fusion Preservative Free eye drops** as directed at least 4 times per day. Additional drops may be used as needed

☐ 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.