

**isatuximab 10 mg/kg -
pomalidomide 4 mg -
dexamethasone 40 mg**

Regimen: Cycle 1 (Part I)
ARIA Protocol Name: Isatuximab Pomalidomide Dex
Adult Chemotherapy - Hematology Oncology
Multiple Myeloma



CC5140 0324 02 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** $1 \times 10^9/L$ 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):

- allopurinol 300 mg PO on day 1
- 30 minutes prior to isatuximab: dexamethasone 40 mg PO on day 1
- 30 minutes prior to isatuximab: montelukast 10 mg PO on day 1, 8, 15 and 22
- 30 minutes prior to isatuximab: acetaminophen 650 mg PO on day 1, 8, 15 and 22
- 30 minutes prior to isatuximab: diphenhydramine 50 mg IV in 50 mL normal saline over 15 minutes on day 1, 8, 15 and 22
- 30 minutes prior to isatuximab: ranitidine 150 mg PO on day 1, 8, 15 and 22

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- allopurinol 300 mg PO once daily on days 2 to 5
- metoclopramide 10-20 mg PO every 4 to 6 hours as needed
- acetylsalicylic acid 81 mg PO once daily continuously while taking pomalidomide
- acyclovir 800 mg PO once daily until 30 days post completion of isatuximab 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.



Doctor's Order Sheet

isatuximab 10 mg/kg
pomalidomide 4 mg -
dexamethasone 40 mg

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Isatuximab Pomalidomide Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC5140 0324 02 2024

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

isatuximab 10 mg/kg X weight (kg) = _____ mg

IV in 250 mL normal saline on day 1, 8, 15 and 22

First infusion: Observe patient for 30 minutes after infusion. Patient may leave when infusion is complete and is stable for 30 minutes

First Infusion: Initial Rate: 25 mL/hour for 60 minutes, if no reaction increase by 25 mL/hour every 30 minutes up to 150 mL/hour.

Second Infusion: Initial Rate: 50 mL/hour for 30 minutes, if no reaction increase by 50 mL/hour for 30 minutes, then increase by 100 mL/hour up to 200 mL/hour.

Subsequent Infusions: Administer over 30 minutes

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

dexamethasone 40 mg

PO 30 minutes pre-isatuximab on day 8, 15 and 22

pomalidomide 4 mg

Dose modification: **pomalidomide 3 mg**

Dose modification: **pomalidomide 2 mg**

Dose modification: **pomalidomide 1 mg**

PO once daily on days 1 to 21 (ensure patient enrolled in managed access program)

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: _____

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