CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

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

Regimen: Cycles 2+ (Part I)

ARIA Protocol Name: Isatuximab Pomalidomide Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC5150 0325 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 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):

☐ **30 minutes prior to isatuximab: acetaminophen 650 mg PO** on day 1 and 15

☐ **30 minutes prior to isatuximab: diphenhydrAMINE 50 mg PO** on day 1 and 15

☐ **30 minutes prior to isatuximab: ranitidine 150 mg PO** on day 1 and 15

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

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

Regimen: Cycles 2+ (Part II)

ARIA Protocol Name: Isatuximab Pomalidomide Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC5150 0325 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 over 30 minutes on day 1 and 15

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg**

PO in the morning on day 1, 8, 15 and 22 (30 minutes pre-isatuximab on day 1 and 15)

☐ **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: _____