CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

isatuximab 10 mg/kg - pomalidomide 4 mg - dexamethasone 20 mg

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Isatuximab Pomalidomide Dex (age & comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC6450 0455 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):

☐ **allopurinol 300 mg PO** on day 1

☐ **30 minutes prior to isatuximab: dexamethasone 20 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

☐ Other: ______________________________

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.

Cancer Care Program

Doctor's Order Sheet

isatuximab 10 mg/kg pomalidomide 4 mg - dexamethasone 20 mg

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Isatuximab Pomalidomide Dex (age & comorbidities)

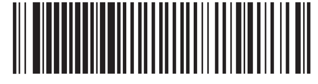
Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:



CC6450 0455 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 20 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: ____

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