CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

tarlatamab 10 mg

Regimen: Cycle 2+

ARIA Protocol Name: tarlatamab Compassionate

Adult Chemotherapy - Medical Oncology

Previously treated extensive stage small cell lung cancer

CC7190 0539 02/2025

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

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 Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ **Other:** _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **tarlatamab 10 mg IV** in 250 mL normal saline over 60 minutes on day 1 and 15

Monitor patients 6-8 hours post infusion during Cycle 2

Monitor patients 3 hours post infusion during Cycles 3 and 4

Monitor patients 2 hours post infusion during Cycles 5 +

This regimen is NOT funded by the Cancer Care Program. Approved only for patients enrolled in the compassionate access. program.

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY): None recommended

☐ **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.