

Doctor's Order Sheet
tarlatamab 1 mg/ 10 mg

Regimen: Cycle 1

ARIA Protocol Name: tarlatamab Compassionate

Adult Chemotherapy - Medical Oncology

Previously treated extensive stage small cell lung cancer



CC7180 0538 02/2025

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

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

PREMEDICATIONS:

60 minutes pre tarlatamab: dexamethasone 8 mg IV in 50 mL normal saline over 15 minutes on day 1 and 8

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

tarlatamab 1 mg IV in 250 mL normal saline over 60 minutes on day 1

tarlatamab 10 mg IV in 250 mL normal saline over 60 minutes on day 8 and 15

Monitor patients from the start of infusion for 24 hours on Cycle 1 day 1 and Cycle 1 day 8 in an appropriate healthcare facility

Monitor patients 6-8 hours post infusion on Cycle 1 day 15 in an appropriate healthcare facility

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):

sodium chloride 0.9% 1000 mL IV over 4 hours immediately post tarlatamab on day 1, 8 and 15

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.