CANCER Care
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

talquetamab 0.4 mg/kg

Regimen: Cycles 2+ (Part I)

ARIA Protocol Name: talquetamab Cycles 2 + (Weekly) Compassionate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma

Name:

HCN:

Date of Birth:

CC7250 0545 04/2025

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** 0.5 X 10^9/L, platelets **greater than or equal to** 25 X 10^9/L and hemoglobin **greater than or equal to** 80g/L otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurologic toxicity assessed
- Skin toxicity assessed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **60 minutes prior to talquetamab: dexamethasone 16 mg PO** on day 1, 8, 15 and 22

☐ **60 minutes prior to talquetamab: acetaminophen 650 mg PO** on day 1, 8, 15 and 22

☐ **60 minutes prior to talquetamab: diphenhydrAMINE 50 mg PO** on day 1, 8, 15 and 22

☐ 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

talquetamab 0.4 mg/kg

Regimen: Cycles 2+ (Part II)

ARIA Protocol Name: talquetamab Cycles 2 + (Weekly) Compassionate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma

CC7250 0545 04/2025

Name:

HCN:

Date of Birth:

Weight: ____________kg Height:_________________cm Body Surface Area (BSA) = ____________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **talquetamab 0.4 mg/kg** X weight (kg)= ___________**mg SUBCUTANEOUS** on day 1, 8, 15 and 22

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **valacyclovir 500 mg PO** twice daily for duration of treatment

☐ **sulfamethoxazole/trimethoprim 400/80 mg PO** once daily for duration of 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: ____

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