

Doctor's Order Sheet

talquetamab 0.8 mg/kg

Regimen: Cycles 2+ (Part I)

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

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma



CC7260 0546 04/2025

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle of

Cycle Duration: 14 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $0.5 \times 10^9/L$, platelets **greater than or equal to** $25 \times 10^9/L$ 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
- 60 minutes prior to talquetamab: acetaminophen 650 mg PO** on day 1
- 60 minutes prior to talquetamab: diphenhydrAMINE 50 mg PO** on day 1
- Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT
DD/MONTH/YYYY

Authorized Prescriber: _____ Date: _____ Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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Doctor's Order Sheet

talquetamab 0.8 mg/kg

Regimen: Cycles 2+ (Part II)

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

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma



CC7260 0546 04/2025

Name: _____

HCN: _____

Date of Birth: _____

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

talquetamab 0.8 mg/kg X weight (kg) = _____ mg **SUBCUTANEOUS** on day 1

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: _____

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Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

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