CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

isatuximab 10 mg/kg - bortezomib 1.3 - lenalidomide 25 mg - dexamethasone 40 mg

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Isatuximab Bortezomib Lenalidomide Dex Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC7360 0556 05 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** 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 40 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

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 lenalidomide

☐**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: _____

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CANCERCare
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Cancer Care Program

Doctor's Order Sheet

isatuximab 10 mg/kg - bortezomib 1.3 - lenalidomide 25 mg - dexamethasone 40 mg

Name:

HCN:

Date of Birth:

Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Isatuximab Bortezomib Lenalidomide Dex Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC7360 0556 05 2025

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

☐ **bortezomib 1.3 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **bortezomib 1.3 mg/m²** X BSA - _____% =_____ **mg**

SC on day 1, 8, 15 and 22

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg PO** 30 minutes pre-isatuximab on day 8,15 and 22

☐ **lenalidomide 25 mg PO** once daily on days 1 to 21 (ensure patient enrolled in managed access program)

☐ Dose modification: **lenalidomide 20 mg PO** once daily on days 1 to 21
☐ Dose modification: **lenalidomide 15 mg PO** once daily on days 1 to 21
☐ Dose modification: **lenalidomide 10 mg PO** once daily on days 1 to 21
☐ Dose modification: **lenalidomide 15 mg PO** every other day on days 1 to 21
☐ Dose modification: **lenalidomide 5 mg PO** once daily on days 1 to 21
☐ Dose modification: **lenalidomide 2.5 mg PO** once daily on days 1 to 21

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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