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 19+ (Part I)

ARIA Protocol Name: Isatuximab Bortezomib Lenalidomide Dex Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC7390 0559 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):

☐ **30 minutes prior to isatuximab: acetaminophen 650 mg PO** on day 1

☐ **30 minutes prior to isatuximab: diphenhydrAMINE 50 mg PO** on day 1

☐ **30 minutes prior to isatuximab: ranitidine 150 mg PO** on day 1

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

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Doctor's Order Sheet

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

Name:

HCN:

Date of Birth:

Regimen: Cycle 19+ (Part II)

ARIA Protocol Name: Isatuximab Bortezomib Lenalidomide Dex Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

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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 over 30 minutes on day 1

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 40 mg PO** on day 1, 8, 15 and 22 (30 minutes pre-isatuximab on day 1)

☐ **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: _____