CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

daratumumab-hyaluronidase 1800 mg - bortezomib 1.3 - lenalidomide 25 mg - dexamethasone 20 mg

Regimen: Cycle 1 (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Daratumumab SC Bortezomib Len Dex (Age and Comorb) Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC7410 0561 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

☐ **60 minutes prior to daratumumab-hyaluronidase: dexamethasone 20 mg PO** on day 1

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

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

☐ **60 minutes prior to daratumumab-hyaluronidase: montelukast 10 mg PO** on day 1

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **allopurinol 300 mg PO** once daily on days 2 to 5

☐ **acetylsalicylic acid 81 mg PO** once daily

☐**acyclovir 800 mg PO** once daily until 4 weeks post completion of daratumumab treatment

☐ **metoclopramide 10-20 mg PO** every 4 hours as needed

☐ 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

daratumumab-hylauronidase 1800 mg - bortezomib 1.3 - lenalidomide 25/10 mg - dexamethasone 20 mg Regimen: Cycle 1 (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Daratumumab SC Bortezomib Len Dex (Age and Comorb) Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC7410 0561 05 2025

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **daratumumab-hyaluronidase 1800 mg**

SC on day 1, 8, 15 and 22

Administer over 3 to 5 minutes into abdomen

First injection: Observe patient for 4 hours after daratumumab-hyaluronidase SC injection

Subsequent injections: If no reaction in previous injection, observe patient for 15 to 20 minutes after daratumumab-hyaluronidase SC injection

☐ **bortezomib 1.3 mg/m^2** X BSA **=** _____ **mg**

☐ Dose modification: **bortezomib 1.3 mg/m^2** X BSA - _____% =_____ **mg**

SC on day 1, 8, 15 and 22

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 8 mg PO** once daily in the morning on day 2, 9, 16 and 23

☐ **dexamethasone 20 mg PO** 60 minutes pre daratumumab-hyaluronidase 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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