

**daratumumab-hyaluronidase
1800 mg – bortezomib 1.3 -
lenalidomide 25/10 mg -
dexamethasone 40 mg**

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Daratumumab SC Bortezomib Len Dex Compassionate
Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC7400 0560 05 2025

Name: _____

HCN: _____

Date of Birth: _____

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 $1 \times 10^9/L$ and platelets greater than or equal to $50 \times 10^9/L$, 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: _____

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Doctor's Order Sheet

**daratumumab-hyaluronidase
1800 mg – bortezomib 1.3 -
lenalidomide 25/10 mg -**

dexamethasone 40 mg Regimen: Cycle 1 (Part II)

ARIA Protocol Name: Daratumumab SC Bortezomib Len Dex Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC7400 0560 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/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 20 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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