CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

mogamulizumab 1 mg/kg Regimen: Cycle 1

ARIA Protocol Name: mogamulizumab

Adult Chemotherapy - Hematology Oncology

Non Hodgkins Lymphoma - Mycosis Fungoides

Name:

HCN:

Date of Birth:

CC6590 0479 04 2024

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.
- Dermatologic toxicity assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **allopurinol 300 mg PO** pre-mogamulizumab on day 1

☐ **60 minutes prior to mogamulizumab: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on days 1 and 8

☐ **30 minutes prior to mogamulizumab: acetaminophen 650 mg PO** on days 1 and 8

☐ **30 minutes prior to mogamulizumab: cetirizine 20 mg PO** on days 1 and 8

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ **metoclopramide 10-20 mg PO** every 6 hours as needed

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **mogamulizumab 1 mg/kg X weight (kg) = _____ mg**

IV in 100 mL normal saline over 60 minutes on days 1, 8, 15 and 22 (administer using a 0.2 micron in-line filter)

Observe patient for 60 minutes after the first infusion and for 30 minutes after the second and third infusion. Observation period not required after 3 consecutive treatments with no reaction.

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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