CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

mogamulizumab 1 mg/kg Regimen: Cycles 2 +

ARIA Protocol Name: mogamulizumab

Adult Chemotherapy - Hematology Oncology

Non Hodgkins Lymphoma - Mycosis Fungoides

Name:

HCN:

Date of Birth:

CC6600 0480 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): None recommended

☐ Other: ____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **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 day 1 and 15 (administer using a 0.2 micron in-line filter)

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: ____

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