

Doctor's Order Sheet

belantamab mafodotin

2.5 mg/kg - pomalidomide 4 mg -

dexamethasone 20/40 mg Regimen: Cycle 1 (Part 1)

ARIA Protocol Name: belantamab mafodotin pomalidomide dexamethasone

Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC7800 0600 09 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 X 10⁹/L and platelets **greater than or equal to** 50 X 10⁹/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed.
- Ocular examination assessed

PREMEDICATIONS:

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- acetylsalicylic acid 81 mg PO** once daily
- preservative-free artificial tears topically** to both eyes 4 times a day continuously
- metoclopramide 10-20 mg PO** every 6 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.

Name: _____

HCN: _____

Date of Birth: _____

belantamab mafodotin

2.5 mg/kg - pomalidomide 4 mg -

dexamethasone 20/40 mg Regimen: Cycle 1 (Part 2)

ARIA Protocol Name: belantamab mafodotin pomalidomide dexamethasone

Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- belantamab mafodotin 2.5 mg/kg** X weight (kg) = _____ mg
 - Dose modification: **belantamab mafodotin 1.9 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**
 - Dose modification: **dexamethasone 20 mg**
- PO** on day 1, 8, 15 and 22
- pomalidomide 4 mg PO** once daily on days 1 to 21
 - Dose modification: **pomalidomide 3 mg PO** once daily on days 1 to 21
 - Dose modification: **pomalidomide 2 mg PO** once daily on days 1 to 21
 - Dose modification: **pomalidomide 1 mg PO** once daily on days 1 to 21

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist

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Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

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