CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

belantamab mafodotin 1.9 mg/kg - pomalidomide 4 mg - dexamethasone 20/40 mg Regimen: Cycles 2+ (Part 1)

ARIA Protocol Name: belantamab mafodotin pomalidomide dexamethasone Compassionate

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC7810 0601 09 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.
- Ocular examination assessed (Prior to cycles 2-6 then every 3 months and as clinically indicated)

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.

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **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

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: _____Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: _____ Time: _____

Nurse's Signature: _____