CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

teclistamab 1.5 mg/kg

Regimen: Cycles 2+ (Part I)

ARIA Protocol Name: teclistamab Cycles 2 +

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Multiple Myeloma

CC7850 0605 10/2025

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** 0.5 X 10^9/L and platelets **greater than or equal to** 25 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **60 minutes prior to teclistamab: dexamethasone 16 mg IV** in 50 mL normal saline over 15 minutes on days 1, 8, 15 and 22

☐ **60 minutes prior to teclistamab: acetaminophen 1000 mg PO** on days 1, 8, 15 and 22

☐ **60 minutes prior to teclistamab: cetirizine 20 mg PO** on days 1, 8, 15 and 22

☐ Other: _____

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

DD/MONTH/YYYY

Authorized Prescriber: _____ Date: _____Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

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teclistamab 1.5 mg/kg

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ARIA Protocol Name: teclistamab Cycles 2 +

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **teclistamab 1.5 mg/kg** X weight (kg)= _____**mg SUBCUTANEOUS** on days 1, 8, 15 and 22

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **valacyclovir 500 mg PO** twice daily for duration of treatment

☐ **sulfamethoxazole/trimethoprim 400/80 mg PO** once daily for duration of treatment

☐ Other: _____

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

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