PROTOCOL CODE: UMY0UF (teclistamab)

Cycle 2+

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff, platelets** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to 0.5 x 10^9/L, platelets greater than or equal to 25 x 10^9/L** (without bleeding), and no signs or symptoms of CRS or ICANS.

Dose modification for: ☐ Other Toxicity: _____

Proceed with treatment based on blood work from _____

- Per physician's clinical judgement, physician to ensure prophylaxis with antiviral/antifungal/antibacterial

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **prochlorperazine** 10 mg PO or ☐ **metoclopramide** 10 mg PO prior to each dose of teclistamab

If required (if CRS with prior dose, or when resuming treatment after treatment interruption*)
☐ **dexamethasone 20 mg** ☐ PO or ☐ IV (select one) 60 minutes prior to each dose of teclistamab
☐ **acetaminophen 650 mg to 975 mg** PO prior to each dose of teclistamab

Select one of the following:
☐ **loratadine 20 mg** PO prior to each dose of teclistamab
OR
☐ **diphenhydrAMINE 50 mg** ☐ PO or ☐ IV (select one) prior to each dose of teclistamab

* Refer to Protocol for suggested indications for premedications

☐ **Other:**

****Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT:

teclistamab 1.5 mg/kg x _____ kg = _____mg subcutaneous injection on **Days 1, 8, 15, and 22**

Administer doses greater than 2 mL as two syringes at two separate sites.

Observe for 30 minutes post-injection. Vital signs prior to treatment and at 30 minutes post-injection.

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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DATE:	
RETURN APPOINTMENT ORDERS	
Return in **four** weeks for Doctor and Cycle _____. Book treatment on Days 1, 8, and 15.	
CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis *and* serum free light chain levels every 4 weeks ☐ **Urine protein electrophoresis** every 4 weeks ☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks ☐ **Beta-2 microglobulin** every 4 weeks ☐ **CBC & Diff, platelets** Days 8, 15, 22 ☐ **Creatinine, sodium, potassium** Days 8, 15, 22 ☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22 ☐ **Random glucose** Days 8, 15, 22 ☐ **Calcium, albumin** Days 8, 15, 22 ☐ **Phosphate** ☐ **Magnesium** ☐ **MUGA scan** or ☐ **Echocardiogram** ☐ **ECG** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**