PROTOCOL CODE: ULYOGLOFIT
Cycles 2 to 12

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

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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** 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 50 x 10^9/L**

Dose modification for: ☐ Other Toxicity: _____

Proceed with treatment based on blood work from _____

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

- Physician to ensure antiviral and antimicrobial prophylaxis, if applicable

Cycles 2 and 3:

60 minutes prior to treatment: **dexamethasone 20 mg** IV

30 minutes prior to treatment: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** ☐ PO or ☐ IV (select one)

Cycles 4 to 12:

Optional if CRS with previous dose:

☐ 60 minutes prior to treatment: **dexamethasone 20 mg** IV

30 minutes prior to treatment: **acetaminophen 650 to 975 mg** PO and **diphenhydrAMINE 50 mg** ☐ PO or ☐ IV (select one)

☐ **Other:**

MONITORING:

If Grade 2 or higher CRS with previous dose, inpatient treatment required. Patients to be monitored during infusion and for at least 24 hours after infusion completed. See protocol for details.

Cytokine release syndrome (CRS)
Patients should be closely monitored for early signs and symptoms indicative of CRS – in particular fever (temperature greater than 38 degrees Celsius), chills, hypoxia, hypotension (systolic blood pressure less than 100 mmHg or drop of greater than 20 mmHg from baseline), dyspnea, and tachycardia. Refer to protocol and to the separate SCCRS PPO for specific management of CRS.

ADDITIONAL ORDERS IF INPATIENT TREATMENT:

valACYclovir 500 mg PO once daily
cotrimoxazole 1 DS tablet PO 3 times each week (Monday, Wednesday and Friday)

PREHYDRATION:

☐ 500 mL NS IV over 30 minutes prior to glofitamab

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

PROTOCOL CODE: ULYOGLOFIT

Cycles 2 to 12

DATE:

**** Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

☐ **Cycle 2:**

☐ If no Grade 2 or higher CRS with previous dose: **ambulatory care treatment**

Vital signs prior to glofitamab, at the end of the infusion, and as clinically indicated.

glofitamab 30 mg IV in 100 mL NS over 4 hours

OR

☐ If Grade 2 or higher CRS with previous dose: **inpatient treatment**

In addition to IV for treatment, insert saline lock for emergency management.
Vital signs prior to glofitamab, every hour during infusion, at the end of the infusion, and as clinically indicated.

glofitamab 30 mg IV in 100 mL NS over 8 hours

Concurrent infusion with glofitamab: Infuse NS IV at 20 mL/h via Y-site connector placed immediately before the injection site

☐ **Cycles 3 to 12:**

☐ If no Grade 2 or higher CRS with previous dose: **ambulatory care treatment**

Vital signs prior to glofitamab, at the end of the infusion, and as clinically indicated.

glofitamab 30 mg IV in 100 mL NS over 2 hours

OR

☐ If Grade 2 or higher CRS with previous dose: **inpatient treatment**

In addition to IV for treatment, insert saline lock for emergency management.

Vital signs prior to glofitamab, every hour during infusion, at the end of the infusion, and as clinically indicated.

glofitamab 30 mg IV in 100 mL NS over 4 hours

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. Book treatment on Day 1.
☐ Return in **three** weeks for Doctor and Cycle _____. Admit to hospital for Cycle _____
☐ Last cycle. Return in _____ week(s).

CBC & Diff prior to each cycle

If clinically indicated:

☐ **creatinine** ☐ **sodium** ☐ **potassium** ☐ **phosphate** ☐ **calcium**
☐ **magnesium** ☐ **uric acid** ☐ **albumin** ☐ **total bilirubin** ☐ **ALT**
☐ **alkaline phosphatase** ☐ **GGT** ☐ **LDH** ☐ **random glucose**
☐ **immunoglobulin panel (IgA, IgG, IgM)**
☐ **HBV viral load every 3 months**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: