PROTOCOL CODE: UMYISAPOMD (cycle 2+)

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

Patient RevAid ID:_____

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: _____

Risk Category: ☐ **Female of Childbearing Potential (FCBP) Rx valid for 7 days**

Risk Category: ☐ **Male or Female of non-Childbearing Potential (NCBP)**

****Ensure Red Blood Cell Phenotype **and Group and Screen** for all patients prior to Cycle 1****

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L and eGFR or creatinine clearance as per protocol**

Dose modification for: ☐ **Hematology: _____** ☐ **Other Toxicity: _____**

Proceed with treatment based on blood work from_____ _____

POMALIDOMIDE

One cycle = 28 days

☐ pomalidomide*_____mg po daily, in the evening, on Days 1 to 21 and off for 7 days

☐ pomalidomide* _____ mg po _____

(*available as 4 mg, 3 mg, 2 mg, 1 mg capsules)
***Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based**

☐ FCBP dispense 21 capsules (1 cycle)

☐ For Male and Female NCBP:

MITTE:_____ capsules or _____ cycles . Maximum 63 capsules (3 cycles).
Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

Physician to ensure DVT prophylaxis in place: ☐ ASA, ☐ Warfarin, ☐ low molecular weight heparin, ☐ direct oral anticoagulant or ☐ none

Pharmacy Use for Pomalidomide dispensing:

Part Fill # 1

RevAid confirmation number:

_____

Pomalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Part Fill # 2

RevAid confirmation number:

_____

Pomalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Part Fill # 3

RevAid confirmation number:

_____

Pomalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Special Instructions

DOCTOR'S SIGNATURE:

Physician Revaid ID:

SIGNATURE:

UC:

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STEROID: (select one)* RN to use patient's therapeutic steroid as pre-med for isatuximab.

☐ **PO Only**

☐ **dexamethasone** _____ **mg** PO once weekly on Days 1, 8, 15, and 22. Take dose 30 minutes prior to isatuximab and on weeks without isatuximab, take dose in the morning

OR

☐ **predniSONE** _____ **mg** PO once weekly on Days 1, 8, 15, and 22. Take dose 30 minutes prior to isatuximab and on weeks without isatuximab, take dose in the morning

Pharmacy to dispense four doses for Days 1, 8, 15 and 22.

OR

☐ **PO/IV option**

dexamethasone _____ **mg IV** in 50 mL NS over 15 minutes given 30 minutes prior to treatment on Days 1 and 15
AND
dexamethasone _____ **mg PO** once weekly on Days 8 and 22. Patient to take dose in the morning.

Pharmacy to dispense two doses for Days 8 and 22.

OR

☐ No steroid

***Refer to Protocol for suggested dosing options**

ISATUXIMAB

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

ISATUXIMAB PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm_____.

- If no reaction after 4 consecutive doses of isatuximab, may discontinue acetaminophen, loratadine/diphenhydrAMINE, famotidine and montelukast

30 minutes prior to isatuximab infusion:

dexamethasone or **predniSONE** as ordered in steroid section

☐ **montelukast 10mg** PO prior to each isatuximab

acetaminophen 650 mg PO prior to each isatuximab. Repeat **acetaminophen 650 mg** PO every 4 hours when needed if IV infusion exceeds 4 hours

Select one of the following:

☐ **loratadine 10 mg** PO prior to each isatuximab, then **diphenhydrAMINE 50 mg** IV every 4 hours when needed for isatuximab reaction

OR

☐ **diphenhydrAMINE 50 mg** ☐PO or ☐ IV prior to each isatuximab. Repeat **diphenhydrAMINE 50 mg** IV every 4 hours when needed for isatuximab reaction

Optional (See protocol):

☐ **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible with diphenhydrAMINE, if using)

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

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

ISATUXIMAB

CYCLE 2 onwards, Days 1 and 15:

isatuximab 10 mg/kg x _____ kg = _____mg **IV in 250 mL NS (use 0.2 micron in-line filter)**

Infusion rate for cycle 2 onwards: Physician to determine rate of infusion

If no reaction in the previous infusion or reaction is Grade 2 or less:

☐ Infuse over 30 minutes.

OR

If reaction in the previous infusion is Grade 3:

☐ Start at 100 mL/hour. If no infusion-related reactions after 60 minutes, increase by 50 mL/hour every 60 minutes to a maximum rate of 200 mL/hour.

Vital signs immediately before the start, at the end of the infusion and as needed. Vital signs not required after 4 treatments with no infusion reaction.

OPTIONAL CYCLOPHOSPHAMIDE:

☐ **cyclophosphamide 500 mg** PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles.

OR

☐ **cyclophosphamide _____ mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for 14 doses. Dispense ____ cycles.

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

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RETURN APPOINTMENT ORDERS

Book chemo on Days 1 and 15

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Return in **eight** weeks for Doctor and Cycles _____ and _____.
Book chemo x 2 cycles.

☐ Return in **twelve** weeks for Doctor and Cycles _____, _____ and _____.
Book chemo x 3 cycles

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, 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

TSH every three months (i.e. prior to cycles 4, 7, 10, 13 etc)

☐ **Urine protein electrophoresis** every 4 weeks

☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks

☐ **Beta-2 microglobulin** every 4 weeks

☐ **CBC & Diff** on Days 8, 15, 22

☐ **Creatinine, sodium, potassium** on Days 8, 15, 22

☐ **Total bilirubin, ALT, alkaline phosphatase** on Days 8, 15, 22

☐ **Random glucose** on Days 8, 15, 22

☐ **Calcium, albumin** on Days 8, 15, 22

☐ **Quantitative beta-hCG blood test for FCBP,** every 4 weeks, less than or equal to 7 days prior to the next cycle

☐ **HBV viral load** prior to next cycle

☐ **Other tests**

☐ **Consults:**

☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: