BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: ULY0UF (epcoritamab)

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**___________**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** day of treatment

May proceed with doses as written if within 48 hours **ANC <u>greater than or equal to</u> 0.5 x 10^9/L, platelets <u>greater than or equal to</u> 50 x 10^9/L.**

Proceed with treatment based on blood work from ________________________

- Physician to ensure antimicrobial prophylaxis

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

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

If required (if Grade 2 or 3 CRS with prior dose)
☐ **dexamethasone 16 mg** ☐ PO or ☐ IV (select one) 30 to 60 minutes prior to each dose epcoritamab

☐ **Other:**

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

TREATMENT:

☐ **CYCLE #______ (Cycle 2 and 3):**

epcoritamab 48 mg subcutaneous injection on **Days 1, 8, 15, and 22**

☐ **CYCLE #______ (Cycle 4 to 9):**

epcoritamab 48 mg subcutaneous injection on **Days 1 and 15**

☐ **CYCLE #______ (Cycle 10 onwards):**

epcoritamab 48 mg subcutaneous injection on **Day 1**

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, 15 and 22.
☐ Return in **four** weeks for Doctor and Cycle ________. Book treatment on Days 1 and 15.
☐ Return in **four** weeks for Doctor and Cycle ________. Book treatment on Days 1 only.

Prior to each treatment: **CBC & Diff**

If clinically indicated:

☐ **Creatinine** ☐ **Sodium, potassium** ☐ **Total bilirubin**
☐**Alkaline phosphatase** ☐ **LDH** ☐ **Calcium** ☐ **ALT**
☐ **Phosphate** ☐ **Magnesium** ☐ **Uric acid** ☐**Albumin** ☐**Glucose**
☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: