ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. This plan is intended for use in non-oncology indications only.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. Type and Screen patients prior to starting 1st treatment. Inform blood blanks that a patient has received daratumumab.
4. Initiate antiviral prophylaxis to prevent herpes zoster reactivation within 1 week after starting DARZALEX FASPRO and continue for 3 months following last treatment dose
5. Patients with history of COPD may require additional post-infusion medications to manage respiratory complications. Consider prescribing short-and long-acting bronchodilators and inhaled corticosteroids for patients with COPD.

PRE-SCREENING:

- ☐ Hepatitis B surface antigen and core antibody total test results scanned with orders.
- ☐ Type and Screen patients prior to starting 1st treatment. Inform blood blanks that a patient has received daratumumab.

LABS:

- ☐ CBC with differential, Routine, ONCE, every visit
- ☐ ABO & RH Type, routine, ONCE, every visit
- ☐ Antigen typing, RBC (Daratumumab – KELL), K antigen phenotype, ONCE, every visit

NURSING ORDERS:

1. Nursing Communication:
    a. Hypersensitivity/Infusion Reaction
        i. No routine observation required for SUBCUTANEOUS daratumumab. If patient experiences a reaction, then subsequent doses require a 6 hour monitoring period.
    b. Patient Instruction
        i. Ensure patient has acetaminophen, acyclovir, and diphenhydramine available at home. Instruct patient to call clinic immediately for symptoms including fever, hives, chills, rigors, or shortness of breath. Please remind patients to call the triage hotline if experiencing symptoms of hypersensitivity. For fever, chills, rhinorrhea – take acetaminophen 650 mg by mouth once and diphenhydramine 50 mg by mouth once and

then call the triage hotline. For hives – diphenhydramine 50 mg by mouth once and call the triage hotline. For breathing changes of dyspnea – diphenhydramine 50 mg by mouth and dial 911.

ii. Ensure patient has an active prescription for dexamethasone and remind patient to take dexamethasone as prescribed.

2. Treatment Parameters:
   a. Hold treatment and notify provider if patient did not have red blood cell antibody screening prior to treatment, or if hepatitis B screening has not been performed or shows positive HepB surface antigen or core antibody.
   b. Hold treatment and notify provider for ANC less than 1000, or platelets less than 50,000

PRE-MEDICATIONS: (Administer 30 minutes prior to injection)

- ☐ Provider to pharmacist communication: If patient tolerates 1st and 2nd injections without issue, may decrease doses of pre-medications.
- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE, every visit
- ☐ dexAMETHasone (DECADRON) 20 mg, oral, ONCE, every visit
- ☐ montelukast (SINGULAIR) tablet, 10 mg, oral, ONCE, every visit

MEDICATIONS:

daratumumab hyaluronidase-fihj (DARZALEX FASPRO) injection, 1800 mg, subcutaneous
Administer over 3-5 minutes into the subcutaneous tissue of the abdomen about 3 inches (7.5 cm) to the right or left of the navel. FOR SUBCUTANEOUS USE ONLY. Rotate injection site with each administration.

Interval: (must check one)
Once weekly x 8 doses, then once every 2 weeks x 2 doses

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – if hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. Acetaminophen (TYLENOL) tablet, 650 mg, oral, AS NEEDED every 4 hours, for fever related to daratumumab administration.
3. Meperidine (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED x1 dose, for daratumumab administration related severe rigors in the absence of hypotension. Not to exceed 50 mg/hr.
4. Sodium chloride 0.9% IV infusion, 100-200 mL/hr, intravenous, AS NEEDED CONTINUOUS, x1 day, for daratumumab administration related side effects. Infuse when daratumumab is stopped for emergency or PRN medications.
5. Diphenhydramine (BENADRYL) injection, 25–50 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction.
6. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.

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7. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
8. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.

TAKE-HOME MEDICATIONS

☐ acyclovir 800 mg oral tablet
SIG: Take 1 tablet by mouth once daily
Quantity: 30 tablets, Refills: 5

☐ dexAMETHasone 4 mg oral tablet
SIG: Take 1 tablet by mouth once daily. Take every morning for 2 days. Start on the following day after injection.
Quantity: 8 tablets, Refills: 2

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

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Contact Referral Team directly for assistance at the centralized numbers below (do not fax/call individual clinics). **INFUSION REFERRAL TEAM** **Fax completed orders to (503) 346-8058** Phone (providers only) (971) 262-9645	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
	☐ **Non-Legacy community providers only** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216
Infusion orders located at: www.ohsuknight.com/infusionorders	Referral team will consider other locations as appropriate if selected site is not available, if treatment is urgent, or for patient preference.	