



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

PROTOCOL CODE: UMYLENDEX Page 1 of 2

Patient RevAid ID: _____

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

<p>DOCTOR'S ORDERS DATE: _____</p>	<p>Pharmacy Use Only:</p>
<p>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form</p>	<p>Part Fill RevAid confirmation and date</p>
<p>Risk Category: <input type="checkbox"/> Female of Childbearing Potential (FCBP) Rx valid 7 days Risk Category: <input type="checkbox"/> Male or Female of non Childbearing Potential (NCBP) Rx valid 30 days</p> <p>START DATE OF THIS CYCLE _____ Cycle # _____ START DATE OF SUBSEQUENT CYCLES _____ Cycle # _____ & _____</p>	<p># 1 _____ date _____</p> <p># 2 _____ date _____</p> <p># 3 _____ date _____</p>
<p><input type="checkbox"/> Delay treatment _____ week(s) May proceed with doses as written if within 7 days ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 30 x 10⁹/L and eGFR as per protocol Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal Function <input type="checkbox"/> Other Toxicity OR Proceed with treatment based on blood work from _____</p>	<p>Part Fill Lenalidomide lot #</p> <p># 1 _____</p> <p># 2 _____</p> <p># 3 _____</p>
<p>LENALIDOMIDE One cycle = 28 days <input type="checkbox"/> Lenalidomide* _____ mg po daily, in the evening, on days 1-21 and off for 7 days <input type="checkbox"/> Lenalidomide* _____ mg po _____</p> <p>MITTE: (*available as 25mg, 15mg, 10mg, 5mg capsules) <input type="checkbox"/> FCBP: dispense 21 capsules (1 cycle) <input type="checkbox"/> For Male and Female NCBP: Dispense _____ capsules. Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time.</p>	<p>Part Fill Pharmacist counsel (initial)</p> <p># 1 _____</p> <p>in person _____ or via phone _____</p>
<p>STEROID*: CHOOSE ONE One cycle = 28 days <input type="checkbox"/> Dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg po once weekly, in the morning, x _____ doses OR number of 28 day cycles _____ <input type="checkbox"/> Dexamethasone _____ mg po _____, in the morning, x _____ doses OR number of 28 day cycles _____ <input type="checkbox"/> Prednisone _____ mg po _____, in the morning, x _____ doses <input type="checkbox"/> No Steroid *Refer to Protocol for steroid dosing options</p>	<p>Pharmacist counsel (initial) # 2 _____</p> <p>in person _____ or via phone _____</p> <p>Pharmacist counsel (initial) # 3 _____</p> <p>in person _____ or via phone _____</p>
<p>Physician to assure DVT prophylaxis in place: ASA or Warfarin or LMWH or none</p>	
<p>Special Instructions</p>	
<p>DOCTOR'S SIGNATURE:</p>	<p>SIGNATURE:</p>
<p>Physician RevAid ID:</p>	<p>UC:</p>



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RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____	
<input type="checkbox"/> Last cycle. Return in _____ week(s).	
Laboratory: Cycles 1-4: CBC & Diff, Platelets, Creatinine, Calcium every two weeks Serum Protein Electrophoresis (SPE) every 4 weeks: Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date Cycles 5 and subsequent cycles: CBC & Diff, Platelets, Creatinine, Calcium, Serum Protein Electrophoresis (SPE) Every 4 weeks, less than or equal to 7 days prior to the next cycle T3, T4, TSH Every three months <input type="checkbox"/> Pregnancy blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle	
<input type="checkbox"/> Serum Free Light Chain Levels	
<input type="checkbox"/> Other tests	
<input type="checkbox"/> Consults:	
<input type="checkbox"/> See general orders sheet for additional requests	
DOCTOR'S SIGNATURE: 	SIGNATURE: UC: