BC Cancer Agency
CARE & RESEARCH

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: UMYTHALID

Patient RevAid ID:________

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

DOCTOR'S ORDERS

DATE:

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

Risk Category: ☐ **Female of Childbearing Potential (FCBP) Rx valid 7 days**
Risk Category: ☐ **Male or Female of non Childbearing Potential (NCBP) Rx valid 30 days**

No hematological or renal dose modifications are required for thalidomide. Dose modifications considered for peripheral neuropathy, constipation and somnolence.

THALIDOMIDE:

Thalidomide ______________ **mg** PO daily at bedtime

OR

Thalidomide ______________ **mg** PO BID

OR

Thalidomide ______________ **mg** PO TID

OR

Thalidomide ______________ **mg** PO QID

MITTE: *check one box below* (*available as 50 mg, 100 mg, 200 mg capsules)

☐ FCBP: dispense 28 supply

☐ For Male and Female NCBP:
Dispense number of 28 day cycles _____. Maximum 3 cycles supply. Pharmacy to dispense one cycle at a time.

STEROID (Optional):

Dexamethasone or prednisone *(circle one)* ________ mg PO in morning with food on days ____
x _________ doses
OR number of 28 day cycles_______

Refer to Protocol for suggested dosing options

Physician to ensure DVT prophylaxis in place: ASA or Warfarin or LMWH or None

Special Instructions

Pharmacy Use for thalidomide dispensing:

Part Fill
RevAid confirmation and date

 # 1 ______________________

date______________________

 # 2______________________

date______________________

 # 3______________________

date______________________

Part Fill
Thalidomide lot #

 # 1______________________

 # 2______________________

 # 3______________________

Part Fill
Pharmacist counsel (initial)

#1 in person____ or via phone____

#2 in person____ or via phone____

#3 in person____ or via phone____

DOCTOR'S SIGNATURE:

Physician RevAid ID:

SIGNATURE:

UC:

BC Cancer Agency
CARE & RESEARCH

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: UMYTHALID

RETURN APPOINTMENT ORDERS	
☐ Return in _______ weeks for Doctor and Cycle _________ ☐ Last cycle. Return in ________week(s).	
Laboratory: **CBC and Diff, Platelets, Creatinine, Calcium & SPE every 28 days** T3, T4, TSH every three months ☐ **If female of child bearing potential: Serum pregnancy test every 4 weeks.**	
☐ **Serum Free Light Chain Levels** ☐ **Other tests** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**