



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: ULKMDSL

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

DOCTOR'S ORDERS		Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form				
DATE: _____				
<input type="checkbox"/> Female of Childbearing Potential (FCBP) Rx valid 7 days <input type="checkbox"/> non Childbearing Potential (non CBP) Rx valid 14 days				
START DATE OF THIS CYCLE _____ Cycle # _____				
Physician RevAid Unique ID # : _____ Dispensing Confirmation # _____ (pharmacy use only)				
Patient RevAid Unique ID # : _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets, Serum Creatinine, Pregnancy Test (for FCBP*), TSH May proceed with doses as written if within 7 days ANC <u>greater than or equal to</u> $1 \times 10^9/L$, Platelets <u>greater than or equal to</u> $50 \times 10^9/L$ Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal Function <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
CHEMOTHERAPY:				
One cycle = 21 days therapy + 7 days off = 28 days				
<input type="checkbox"/> Lenalidomide 10 mg PO once daily for 3 weeks followed by 1 week rest. Mitte: 28 day supply (for FCBP) or 84 day supply for Non FCBP, male _____ capsules OR <input type="checkbox"/> Lenalidomide 5 mg PO once daily for 3 weeks followed by 1 week rest. Mitte: 28 day supply (for FCBP) or 84 day supply for Non FCBP, male _____ capsules *available as 25mg, 15mg, 10mg, 5mg capsules				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____. <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets, Creatinine, Pregnancy Test (for FCBP) <input type="checkbox"/> weekly x 1 st month <input type="checkbox"/> monthly after 1 st month <input type="checkbox"/> Other tests: TSH 3-monthly after 1 st month therapy <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests. *FCBP = Females of child bearing potential.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: