



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: MYBLDF

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Patient RevAid ID: _____

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:	To be given: Cycle #:
Date of Previous Cycle: _____	
Risk Category: <input type="checkbox"/> Female of Childbearing Potential (FCBP) Rx valid for 7 days	
Risk Category: <input type="checkbox"/> Male or Female of non-Childbearing Potential (NCBP)	
<input type="checkbox"/> Delay treatment _____ week(s)	
<input type="checkbox"/> CBC & Diff day of treatment	
Proceed with all medications for entire cycle as written, if within 96 hours of Day 1: ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 50 x 10⁹/L and eGFR or creatinine clearance as per protocol	
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 _____	
LENALIDOMIDE One cycle = 28 days <input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days <input type="checkbox"/> lenalidomide* _____ mg PO _____ (*available as 25 mg, 20 mg, 15 mg, 10 mg, 5 mg, 2.5 mg capsules) *Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based <input type="checkbox"/> FCBP dispense 21 capsules (1 cycle) <input type="checkbox"/> For Male and Female NCBP: MITTE: _____ capsules or _____ cycles . Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed	Pharmacy Use for Lenalidomide dispensing: Part Fill # 1 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____ Part Fill # 2 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____ Part Fill # 3 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____
STEROID (select one)* <input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> dexamethasone _____ mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> predniSONE _____ mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> No Steroid *Refer to Protocol for steroid dosing options Physician to ensure DVT prophylaxis in place: <input type="checkbox"/> ASA , <input type="checkbox"/> Warfarin , <input type="checkbox"/> low molecular weight heparin , <input type="checkbox"/> direct oral anticoagulant or <input type="checkbox"/> none (select one)	
Special Instructions	
DOCTOR'S SIGNATURE: Physician RevAid ID:	SIGNATURE: UC:



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DATE:	
TREATMENT: <ul style="list-style-type: none">Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily	
CYCLE # _____ (Cycles 1 to 8)	
bortezomib <input type="checkbox"/> 1.5 mg/m ² or <input type="checkbox"/> 1.3 mg/m ² or <input type="checkbox"/> 1 mg/m ² or <input type="checkbox"/> 0.7 mg/m ² or <input type="checkbox"/> 0.5 mg/m ² (select one) x BSA = _____ mg subcutaneous injection on Days 1, 8 and 15	
RETURN APPOINTMENT ORDERS	
For Cycles 1 to 8, book chemo on Days 1, 8, 15 <input type="checkbox"/> Return in four weeks for Doctor and Cycle _____ <input type="checkbox"/> Last cycle. Return in _____ week(s)	
CBC & Diff, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis and serum free light chain levels every 4 weeks TSH every three months (i.e. prior to cycles 4, 7, 10, 13, 16 etc) <input type="checkbox"/> Urine protein electrophoresis every 4 weeks <input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks <input type="checkbox"/> Beta-2 microglobulin every 4 weeks <input type="checkbox"/> CBC & Diff Days 8, 15, 22 <input type="checkbox"/> Creatinine, sodium, potassium Days 8, 15, 22 <input type="checkbox"/> Total bilirubin, ALT, alkaline phosphatase Days 8, 15, 22 <input type="checkbox"/> Random glucose Days 8, 15, 22 <input type="checkbox"/> Calcium, albumin Days 8, 15, 22 <input type="checkbox"/> Quantitative beta-hCG blood test for FCBP 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1 <input type="checkbox"/> Quantitative beta-hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle <input type="checkbox"/> HBV viral load <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: