



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: MYLDREL

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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 nonChildbearing Potential (NCBP)	
<input type="checkbox"/> Delay treatment _____ week(s)	
<input type="checkbox"/> CBC & Diff day of treatment	
Proceed with doses as written if within 7 days: ANC greater than or equal to $1.0 \times 10^9/L$, platelets greater than or equal to $50 \times 10^9/L$ 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 <ul style="list-style-type: none">• Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily<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)* 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 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:	SIGNATURE:
Physician RevAid ID:	UC:



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DATE:	
OPTIONAL CYCLOPHOSPHAMIDE:	
<input type="checkbox"/> cyclophosphamide 500 mg PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles.	
OR	
<input type="checkbox"/> cyclophosphamide ____ mg PO once weekly in the morning on Days ____ Dispense ____ cycles.	
OR	
<input type="checkbox"/> cyclophosphamide 50 mg PO once in the morning every 2 days for ____ doses. Dispense ____ cycles	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in ____ 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 <u>and</u> 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 prior to next cycle	
<input type="checkbox"/> Other tests	
<input type="checkbox"/> Consults:	
<input type="checkbox"/> See general orders sheet for additional requests	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: