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

Patient RevAid ID:________

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)**
Risk Category: ☐ **Male or Female of nonChildbearing Potential (NCBP)**

START DATE OF THIS CYCLE ______________________ Cycle # ________
START DATE OF SUBSEQUENT CYCLES______________ Cycle # ____&____

☐ Delay treatment ______ week(s)
May proceed with doses as written if within **7 days**
ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L and eGFR as per protocol
Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**
OR Proceed with treatment based on blood work from________________________

LENALIDOMIDE
One cycle = 28 days
☐ lenalidomide* ______mg PO daily, in the evening, on days 1 to 21 and off for 7 days
☐ 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**
☐ FCBP dispense 21 capsules (1 cycle)
☐ 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

STEROID*: CHOOSE ONE
One cycle = 28 days
☐ dexamethasone ☐ 40 mg or ☐ 20 mg PO once weekly, in the morning, x ☐ ________ doses **OR** ☐ number of 28 day cycles_______(select one)
☐ dexamethasone ________mg PO once weekly in the morning, x ☐ ______ doses **OR** ☐ number of 28 day cycles_______ (select one)
☐ predniSONE ________mg PO once weekly in the morning, x ☐ _____doses **OR** ☐ number of 28 day cycles_______ (select one)
☐ No Steroid
***Refer to Protocol for steroid dosing options**

Physician to assure DVT prophylaxis in place: ASA, Warfarin , low molecular weight heparin, direct oral anticoagulant or none

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): ________________

Special Instructions

DOCTOR'S SIGNATURE:

Physician RevAid ID:

SIGNATURE:

UC:

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DATE:

OPTIONAL CYCLOPHOSPHAMIDE:

☐ cyclophosphamide 500 mg PO once weekly in the morning on days 1, 8, 15 and 22 for _______doses OR ☐ number of 28 day cycles _____ (select one).

OR

☐ cyclophosphamide 50 mg PO once in the morning every 2 days for _____ doses OR ☐ number of 28 day cycles _____ (select one).

RETURN APPOINTMENT ORDERS	
☐ Return in _______ weeks for Doctor and Cycle _________ ☐ Last cycle. Return in ________week(s)	
Laboratory: Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date **CBC & Diff, Platelets, Creatinine, Calcium, Serum Protein Electrophoresis** and **Serum Free Light Chain Levels** every 4 weeks **TSH** every three months (i.e. prior to cycles 1, 4, 7, 10,13 etc) ☐ **CBC & Diff, Platelets, Creatinine, Calcium** every two weeks for Cycles 1 to 4 ☐ **Urine protein electrophoresis** every 4 weeks ☐ **Immunoglobulin (IgA, IgG, IgM)** every 4 weeks ☐ **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 ☐ **Quantitative beta-hCG blood test** for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle ☐ **Bilirubin, ALT** ☐ **Other tests** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**