PROTOCOL CODE: MYLENMTN

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 non-Childbearing 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 30 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 28 continuously

☐ lenalidomide* _____mg po daily, in the evening, on *days 1 to 21 and off for 7 days*

☐ lenalidomide* _____ mg po _____

MITTE: (*available as 5 mg, 10 mg, 15 mg capsules
***NB** Use one capsule for the total dose i.e., one 5 mg capsule or one 10 mg capsule or one 15 mg capsule due to budget considerations

☐ FCBP dispense Maximum 1 cycle (28 capsules for 28/28 days, 21 capsules *for 21/28 days*).

☐ For Male and Female NCBP:

Dispense_____ capsules or _____ cycles. Maximum 3 cycles (84 capsules for 28/28 days, 63 capsules *for 21/28 days*).

Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

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:

DATE:	
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 panel (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:**