

**PROTOCOL CODE: UMYBLDF**

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Patient RevAid ID: \_\_\_\_\_

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>		
<b>DATE:</b> _____	<b>To be given:</b> _____	<b>Cycle #:</b> _____
Date of Previous Cycle: _____		
Risk Category: <input type="checkbox"/> <b>Female of Childbearing Potential (FCBP)</b> Rx valid for 7 days		
Risk Category: <input type="checkbox"/> <b>Male or Female of non-Childbearing Potential (NCBP)</b>		
<input type="checkbox"/> Delay treatment _____ week(s) <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>CBC and Diff, Platelets, Creatinine, ALT, Bilirubin</b> on day of treatment</li> <li><input type="checkbox"/> <b>CBC on day of treatment</b></li> </ul> <ul style="list-style-type: none"> <li>• May proceed with lenalidomide dose day 1 as written, if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 50 x 10<sup>9</sup>/L and eGFR as per protocol</b></li> <li>• May proceed with bortezomib dose day 1 as written, if within 96 hours <b>ANC greater than or equal to 0.5 x 10<sup>9</sup>/L, platelets greater than or equal to 50 x 10<sup>9</sup>/L, bilirubin less than or equal to 1.5 x upper limit of normal</b></li> <li>• If CBC prior to day 1 show ANC less than 1.5 x 10<sup>9</sup>/L or platelets less than 75 x 10<sup>9</sup>/L then:             <ul style="list-style-type: none"> <li>○ May proceed with bortezomib Day 8 and 15 as written, if within 96 hours <b>ANC greater than or equal to 0.5 x 10<sup>9</sup>/L, platelets greater than or equal to 50 x 10<sup>9</sup>/L</b></li> </ul> </li> </ul> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Renal Function</b> <input type="checkbox"/> <b>Other Toxicity</b> Proceed with treatment based on blood work from _____		
<b>LENALIDOMIDE</b> <b>One cycle = 28 days</b> <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) <b>*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based</b> <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	<b>Pharmacy Use for Lenalidomide dispensing:</b>  <b>Part Fill # 1</b>  RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____  <b>Part Fill # 2</b>  RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____  <b>Part Fill # 3</b>  RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____	
<b>STEROID*: CHOOSE ONE</b> <b>One cycle = 28 days</b> <input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO once weekly, in the morning, x <input type="checkbox"/> _____ doses <b>OR</b> <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> dexamethasone _____ mg PO once weekly in the morning, x <input type="checkbox"/> _____ doses <b>OR</b> <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> predniSONE _____ mg PO once weekly in the morning, x _____ doses <b>OR</b> <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> No Steroid <b>*Refer to Protocol for steroid dosing options</b>  <b>Physician to ensure DVT prophylaxis in place:</b> <input type="checkbox"/> <b>ASA</b> , <input type="checkbox"/> <b>Warfarin</b> , <input type="checkbox"/> <b>low molecular weight heparin</b> , <input type="checkbox"/> <b>direct oral anticoagulant</b> or <input type="checkbox"/> <b>none</b> (select one)		
<b>Special Instructions</b>		
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>	
<b>Physician RevAid ID:</b>	<b>UC:</b>	



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

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<b>DATE:</b>	
<b>TREATMENT:</b> If patient is VZV seropositive and/or at physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg daily while on bortezomib and for 4 weeks after discontinuation	
<b>CYCLE # _____ (Cycles 1 to 8)</b>	
<b>bortezomib</b> <input type="checkbox"/> 1.3 mg /m <sup>2</sup> or <input type="checkbox"/> 1 mg/m <sup>2</sup> or <input type="checkbox"/> 0.7 mg/m <sup>2</sup> (select one) x BSA = _____ mg SC injection on days 1, 8, and 15	
<b>RETURN APPOINTMENT ORDERS</b>	
For Cycles 1 to 8, book chemo on Days 1, 8 and 15	
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____	
<input type="checkbox"/> Last cycle. Return in _____ week(s)	
<b>Laboratory:</b> Blood work done prior to next cycle must be done less than or equal to 4 days prior to the start date	
<b>TSH</b> every three months (i.e. prior to cycles 1, 4, 7, 10,13 etc)	
<b>Cycles 1 to 4:</b> <b>CBC and Diff, Platelets, Creatinine, Calcium</b> every two weeks	
Day 1: <b>CBC and Diff, Platelets, Creatinine, Calcium, bilirubin, ALT</b>	
<input type="checkbox"/> <b>Serum Protein Electrophoresis and/or</b> <input type="checkbox"/> <b>Serum Free Light Chain Levels</b> (SELECT APPROPRIATE)	
<b>CBC and Diff, Platelets</b> on Day 8 and 15 for current cycle if ANC on Day 1 is less than 1.5 x 10 <sup>9</sup> /L or Platelets are less than 100 x 10 <sup>9</sup> /L	
<b>Cycles 5 to 8:</b> Day 1: <b>CBC and Diff, Platelets, Creatinine, Calcium, bilirubin, ALT</b>	
<input type="checkbox"/> <b>Serum Protein Electrophoresis and/or</b> <input type="checkbox"/> <b>Serum Free Light Chain Levels</b> (SELECT APPROPRIATE)	
<b>CBC and Diff, Platelets</b> on Day 8 and 15 for current cycle if ANC on Day 1 is less than 1.5 x 10 <sup>9</sup> /L or Platelets are less than 75 x 10 <sup>9</sup> /L	
<b>Cycle 9 and subsequent cycles:</b> Day 1: <b>CBC and Diff, Platelets, Creatinine, Calcium, bilirubin, ALT</b>	
<input type="checkbox"/> <b>Serum Protein Electrophoresis and/or</b> <input type="checkbox"/> <b>Serum Free Light Chain Levels</b> (SELECT APPROPRIATE)	
<input type="checkbox"/> <b>Quantitative beta-hCG blood test</b> for FCBP 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1	
<input type="checkbox"/> <b>Quantitative beta-hCG blood test</b> for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle	
<input type="checkbox"/> <b>Other tests</b> <input type="checkbox"/> <b>Consults:</b>	
<input type="checkbox"/> <b>See general orders sheet for additional requests</b>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b> <b>UC:</b>