PROTOCOL CODE: UMYLDF

Patient RevAid ID:_____

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

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: ☐ **Female of Childbearing Potential (FCBP)** Rx valid for 7 days
Risk Category: ☐ **Male or Female of non-Childbearing Potential (NCBP)**

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment
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 or creatinine clearance as per protocol**
Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**
Proceed with treatment based on blood work from_____

LENALIDOMIDE

One cycle = 28 days

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

☐ **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 (select one)*

One cycle = 28 days

☐ dexamethasone ☐ 40 mg or ☐ 20 mg PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ dexamethasone _____mg PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ predniSONE _____mg PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ No Steroid

***Refer to Protocol for steroid dosing options**

Physician to ensure DVT prophylaxis in place: ☐ ASA, ☐ Warfarin, ☐ low molecular weight heparin, ☐ direct oral anticoagulant or ☐ none (select one)

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:

OPTIONAL CYCLOPHOSPHAMIDE:

☐ **cyclophosphamide 500 mg** PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles.

OR

☐ **cyclophosphamide _____ mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for _____ doses. Dispense ____ cycles

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____

☐ 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 etc)

☐ **Urine protein electrophoresis** every 4 weeks

☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks

☐ **Beta-2 microglobulin** every 4 weeks

☐ **CBC & Diff** Days 8, 15, 22

☐ **Creatinine, sodium, potassium** Days 8, 15, 22

☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22

☐ **Random glucose** Days 8, 15, 22

☐ **Calcium, albumin** Days 8, 15, 22

☐ **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

☐ **HBV viral load** prior to next cycle

☐ **Other tests**

☐ **Consults:**

☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: