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

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 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 ensure 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:

Cycles 1-4:
CBC & Diff, Platelets, Creatinine, Calcium every two weeks

Serum Protein Electrophoresis and/or Serum Free Light Chain Levels (CIRCLE APPROPRIATE) every 4 weeks

Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date

Cycles 5 and subsequent cycles:
CBC & Diff, Platelets, Creatinine, Calcium every 4 weeks, less than or equal to 7 days prior to the next cycle

Serum Protein Electrophoresis and/or Serum Free Light Chain Levels (CIRCLE APPROPRIATE) every 4 weeks

TSH Every three months

☐ **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: