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

### DOCTOR’S ORDERS

<table>
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<th>Date: ______________________</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

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

**START DATE OF THIS CYCLE**

**START DATE OF SUBSEQUENT CYCLES**

**Cycle # ______**

**Cycle # ______ & ______**

☐ Delay treatment ______ week(s)

May proceed with doses as written if within 7 days

- ANC greater than or equal to 1 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 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. Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time

### 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_____
- ☐ dexamethasone ______ mg PO, in the morning, x ______ doses OR number of 28 day cycles_____
- ☐ predniSONE ______ mg PO, in the morning, x ______ doses
- ☐ No Steroid

*Refer to Protocol for steroid dosing options

Physician to assure DVT prophylaxis in place: aspirin or Warfarin or low molecular weight heparin or none

**Special Instructions**

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**DOCTOR’S SIGNATURE:**

Physician RevAid ID: ______

**SIGNATURE:**

Physician RevAid ID: ______

UC:
### 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

- [ ] Pregnancy 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: |