**DOCTOR’S ORDERS**

**DATE:** ________________________________

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female of Childbearing Potential (FCBP)</td>
<td>☐</td>
</tr>
<tr>
<td>Male or Female of non Childbearing Potential (NCBP)</td>
<td>☐</td>
</tr>
</tbody>
</table>

**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** $1.0 \times 10^9/L$, **Platelets greater than or equal to** $30 \times 10^9/L$ 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. Maximum 3 cycles (84 capsules for 28/28 days, 63 capsules for 21/28 days). Pharmacy to dispense one cycle at a time

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

**Special Instructions**

**DOCTOR’S SIGNATURE:** ________________________________

**SIGNATURE:** ________________________________

**Physician RevAid ID:** ________________________________

**UC:** ________________________________
**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

**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:**