

PROTOCOL CODE: UMYLENMTN

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Patient RevAid ID: _____

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

<p>DOCTOR'S ORDERS DATE: _____</p>	<p>Pharmacy Use for Lenalidomide dispensing:</p>
<p>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form</p>	<p>Part Fill # 1</p>
<p>Risk Category: <input type="checkbox"/> Female of Childbearing Potential (FCBP)</p> <p>Risk Category: <input type="checkbox"/> Male or Female of non-Childbearing Potential (NCBP)</p> <p>START DATE OF THIS CYCLE _____ Cycle # _____</p> <p>START DATE OF SUBSEQUENT CYCLES _____ Cycle # ____ & ____</p>	<p>RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>
<p><input type="checkbox"/> Delay treatment _____ week(s)</p> <p>May proceed with doses as written if within 7 days</p> <p>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</p> <p>Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal Function <input type="checkbox"/> Other Toxicity</p> <p>OR Proceed with treatment based on blood work from _____</p>	<p>Part Fill # 2</p> <p>RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>
<p>LENALIDOMIDE</p> <p>One cycle = 28 days</p> <p><input type="checkbox"/> lenalidomide* _____ mg po daily, in the evening, on days 1 to 28 continuously</p> <p><input type="checkbox"/> lenalidomide* _____ mg po daily, in the evening, on <i>days 1 to 21 and off for 7 days</i></p> <p><input type="checkbox"/> lenalidomide* _____ mg po _____</p> <p>MITTE: (*available as 5 mg, 10 mg, 15 mg capsules</p> <p>*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</p> <p><input type="checkbox"/> FCBP dispense Maximum 1 cycle (28 capsules for 28/28 days, 21 capsules for 21/28 days).</p> <p><input type="checkbox"/> For Male and Female NCBP:</p> <p>Dispense _____ capsules or _____ cycles. Maximum 3 cycles (84 capsules for 28/28 days, 63 capsules for 21/28 days).</p> <p>Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed</p> <p>Physician to assure DVT prophylaxis in place: ASA, Warfarin, low molecular weight heparin, direct oral anticoagulant or none</p>	<p>Part Fill # 3</p> <p>RevAid confirmation number: _____</p> <p>Lenalidomide lot number: _____</p> <p>Pharmacist counsel (initial): _____</p>
<p>Special Instructions</p>	
<p>DOCTOR'S SIGNATURE:</p>	<p>SIGNATURE:</p>
<p>Physician RevAid ID:</p>	<p>UC:</p>

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DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ <input type="checkbox"/> Last cycle. Return in _____ week(s)	
<p>Laboratory: Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date</p> <p>Cycles 1 - 4: CBC & Diff, Platelets, Creatinine, Calcium every two weeks</p> <p><input type="checkbox"/> Serum Protein Electrophoresis and/or <input type="checkbox"/> Serum Free Light Chain Levels (SELECT APPROPRIATE) every 4 weeks</p> <p>Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date</p> <p>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</p> <p><input type="checkbox"/> Serum Protein Electrophoresis and/or <input type="checkbox"/> Serum Free Light Chain Levels (SELECT APPROPRIATE) every 4 weeks</p> <p>TSH Every three months</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Quantitative beta-hCG blood test for FCBP, every 4 weeks, less than or equal to 7 days prior to the next cycle</p> <p><input type="checkbox"/> Bilirubin, ALT</p> <p><input type="checkbox"/> Other tests</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: