Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

**PROTOCOL CODE: UMYPOMDEX**

Page 1 of 2

**Patient RevAid ID:** __________

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

### DOCTOR’S ORDERS

**Risk Category:**
- [ ] Female of Childbearing Potential (FCBP)
- [x] Male or Female of non-Childbearing Potential (NCPB)

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

**POMALIDOMIDE**

One cycle = 28 days

- [ ] pomalidomide* ______ mg po daily, in the evening, on days 1 to 21 and off for 7 days
- [ ] pomalidomide* ______ mg po 

**MITTE:** *(available as 4 mg, 3 mg, 2 mg, 1 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:
  - Dispense _____ capsules or ________ cycles. Maximum 252 capsules (12 cycles).

**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 **OR** number of 28 day cycles________
- [ ] No Steroid

*Refer to Protocol for steroid dosing options

**Physician to assure DVT prophylaxis in place: ASA, Warfarin, low molecular weight heparin, direct oral anticoagulant or none**

Special Instructions

**DOCTOR’S SIGNATURE:** __________________________

**Physician RevAid ID:** __________________________

**SIGNATURE:** __________________________

**UC:** __________________________
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<table>
<thead>
<tr>
<th>DATE:</th>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Return in _______ weeks for Doctor and Cycle _________</td>
</tr>
<tr>
<td></td>
<td>□ Last cycle. Return in ________week(s)</td>
</tr>
</tbody>
</table>

**Laboratory:**

**Cycles 1-2:**
- CBC & Diff, Platelets every week
- Creatinine, Calcium every 4 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 3 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 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1
- □ 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:**