PROTOCOL CODE: UMYPOMDEX

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 greater than or equal to 30 mL/min
Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**
OR Proceed with treatment based on blood work from_____

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 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 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:

Pharmacy Use for Pomalidomide dispensing:

Part Fill # 1
RevAid confirmation number: _____
Pomalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 2
RevAid confirmation number: _____
Pomalidomide lot number: _____
Pharmacist counsel (initial): _____

Part Fill # 3
RevAid confirmation number: _____
Pomalidomide lot number: _____
Pharmacist counsel (initial): _____

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in _____ weeks for Doctor and Cycle _____ ☐ Last cycle. Return in _____week(s)	
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 ☐ **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:**