**Patient RevAid ID:**________

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**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</th>
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</thead>
</table>

**Risk Category:**
- Female of Childbearing Potential (FCBP)
- 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 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________

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**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. Maximum 63 capsules (3 cycles). Pharmacy to dispense one cycle at a time

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**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:**

**UC:**
**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

- **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:**