BC CANCER
Provincial Health Services Authority

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: MYLENMTN

Patient RevAid ID:________

DOCTOR'S ORDERS

Ht ____________cm Wt ___________kg BSA____________m²

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

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:___________________
Risk Category: ☐ **Female of Childbearing Potential (FCBP)** Rx valid for 7 days
Risk Category: ☐ **Male or Female of non-Childbearing Potential (NCBP)**

☐ Delay treatment ______ week(s)
☐ **CBC & Diff, platelets** day of treatment
Proceed with doses as written if within 7 days: **ANC greater than or equal to 1.0 x 109/L, platelets greater than or equal to 50 x 109/L and eGFR or creatinine clearance as per protocol**
Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**
Proceed with treatment based on blood work from_________________________

LENALIDOMIDE

One cycle = 28 days

- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

☐ **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 ______________________________________

(*available as 2.5 mg, 5 mg, 10 mg, 15 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 Maximum 1 cycle (28 capsules for 28/28 days, 21 capsules *for* 21/28 *days*).

☐ For Male and Female NCBP:

MITTE :______ capsules or _______ cycles. Maximum 3 cycles
(84 capsules for 28/28 days, 63 capsules *for 21/28 days*).

Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

Physician to ensure DVT prophylaxis in place: ☐ **ASA,** ☐ **Warfarin,** ☐ **low molecular weight heparin,** ☐ **direct oral anticoagulant or** ☐ **none (select one)**

Pharmacy Use for Lenalidomide dispensing:

Part Fill # 1
RevAid confirmation number: ______________
Lenalidomide lot number: ______________
Pharmacist counsel (initial): ______________

Part Fill # 2
RevAid confirmation number: ______________
Lenalidomide lot number: ______________
Pharmacist counsel (initial): ______________

Part Fill # 3
RevAid confirmation number: ______________
Lenalidomide lot number: ______________
Pharmacist counsel (initial): ______________

Special Instructions

DOCTOR'S SIGNATURE:

Physician RevAid ID:

SIGNATURE:

UC:

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DATE:

RETURN APPOINTMENT ORDERS

☐ Return in _______ weeks for Doctor and Cycle _________ ☐ Last cycle. Return in ________week(s)	
CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis *and* serum free light chain levels every 4 weeks **TSH every three months** (i.e. prior to cycles 4, 7, 10, 13, 16 etc) ☐ **CBC & Diff, platelets** Days 8, 15, 22 ☐ **Creatinine, sodium, potassium** Days 8, 15, 22 ☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22 ☐ **Random glucose** Days 8, 15, 22 ☐ **Calcium, albumin** Days 8, 15, 22 ☐ **Urine protein electrophoresis** every 4 weeks ☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks ☐ **Beta-2 microglobulin** every 4 weeks ☐ **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 ☐ **Other tests** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**