PROTOCOL CODE: LYLENR

(Cycles 6 to 12 PO)

Patient RevAid ID:_____

DOCTOR'S ORDERS

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)**
Risk Category: ☐ **Male or Female of non - Childbearing Potential (NCBP)**

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

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 or creatinine clearance as per protocol**

Dose modification for: ☐ **Hematology** ☐ **Renal dysfunction** ☐ **Other toxicity: _____**

Proceed with treatment based on blood work from _____

TREATMENT:

LENALIDOMIDE

One cycle = 28 days

☐ **lenalidomide*** _____ **mg** PO daily, in the evening, on Days 1 to 21 and off for 7 days
☐ **lenalidomide*** _____ **mg** PO _____

(*available as 20 mg, 15 mg, 10 mg, 5 mg and 2.5 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:
Mitte:_____capsules or _____ cycles. Maximum 63 capsules (3 cycles).
Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed

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

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

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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(Cycles 6 to 12 PO)

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in four weeks for Doctor and Cycle_____. ☐ Return in _____ weeks for Doctor and Cycle(s) _____. ☐ Last cycle. Return in _____week(s).	
CBC & Diff, creatinine, ALT, total bilirubin, LDH prior to Day 1 of each cycle **TSH every three months** (i.e. prior to cycles 4, 7, 10, etc.) If clinically indicated: ☐ **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 ☐ **HBV viral load** every 3 months ☐ **CBC & Diff weekly** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**