



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: MYLDREL

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Patient RevAid ID: \_\_\_\_\_

<b>DOCTOR'S ORDERS</b> Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>	
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form	
<b>DATE:</b> _____	<b>To be given:</b> _____
<b>Cycle #:</b> _____	
Date of Previous Cycle: _____	
Risk Category: <input type="checkbox"/> <b>Female of Childbearing Potential (FCBP)</b> Rx valid for 7 days	
Risk Category: <input type="checkbox"/> <b>Male or Female of nonChildbearing Potential (NCBP)</b>	
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, platelets</b> day of treatment Proceed with doses as written if within <b>7 days: ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 50 x 10<sup>9</sup>/L and eGFR or creatinine clearance as per protocol</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Renal Function</b> <input type="checkbox"/> <b>Other Toxicity</b> Proceed with treatment based on blood work from _____	
<b>LENALIDOMIDE</b> <b>One cycle = 28 days</b> <ul style="list-style-type: none"> <li>• Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily</li> <li><input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on Days 1 to 21 and off for 7 days</li> <li><input type="checkbox"/> lenalidomide* _____ mg PO _____</li> </ul> <b>(*available as 25 mg, 20 mg, 15 mg, 10 mg, 5 mg, 2.5 mg capsules)</b> <b>*Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based</b> <input type="checkbox"/> FCBP dispense 21 capsules (1 cycle) <input type="checkbox"/> 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	<b>Pharmacy Use for Lenalidomide dispensing:</b> <b>Part Fill # 1</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____ <b>Part Fill # 2</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____ <b>Part Fill # 3</b> <b>RevAid confirmation number:</b> _____ <b>Lenalidomide lot number:</b> _____ <b>Pharmacist counsel (initial):</b> _____
<b>STEROID (select one)*</b> <b>One cycle = 28 days</b> <input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> dexamethasone _____ mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> predniSONE _____ mg PO once weekly in the morning on Days _____ (write in) of each cycle <input type="checkbox"/> No Steroid <b>*Refer to Protocol for steroid dosing options</b> Physician to ensure DVT prophylaxis in place: <input type="checkbox"/> <b>ASA</b> , <input type="checkbox"/> <b>Warfarin</b> , <input type="checkbox"/> <b>low molecular weight heparin</b> , <input type="checkbox"/> <b>direct oral anticoagulant</b> or <input type="checkbox"/> <b>none</b> (select one)	
<b>Special Instructions</b>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
<b>Physician RevAid ID:</b>	<b>UC:</b>



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<b>DATE:</b>	
<b>OPTIONAL CYCLOPHOSPHAMIDE:</b>	
<input type="checkbox"/> cyclophosphamide <b>500 mg</b> PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles. OR <input type="checkbox"/> cyclophosphamide ____ mg PO once weekly in the morning on Days ____ Dispense ____ cycles. OR <input type="checkbox"/> cyclophosphamide <b>50 mg</b> PO once in the morning every 2 days for ____ doses. Dispense ____ cycles	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in ____ weeks for Doctor and Cycle ____ <input type="checkbox"/> Last cycle. Return in ____ week(s)	
<b>CBC &amp; Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis <u>and</u> serum free light chain levels</b> every 4 weeks  <b>TSH every three months</b> (i.e. prior to cycles 4, 7, 10, 13, 16 etc)	
<input type="checkbox"/> Urine protein electrophoresis every 4 weeks <input type="checkbox"/> Immunoglobulin panel (IgA, IgG, IgM) every 4 weeks <input type="checkbox"/> <b>Beta-2 microglobulin every 4 weeks</b> <input type="checkbox"/> <b>CBC &amp; Diff, platelets</b> Days 8, 15, 22 <input type="checkbox"/> <b>Creatinine, sodium, potassium</b> Days 8, 15, 22 <input type="checkbox"/> <b>Total bilirubin, ALT, alkaline phosphatase</b> Days 8, 15, 22 <input type="checkbox"/> <b>Random glucose</b> Days 8, 15, 22 <input type="checkbox"/> <b>Calcium, albumin</b> Days 8, 15, 22 <input type="checkbox"/> <b>Quantitative beta-hCG blood test for FCBP</b> 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1 <input type="checkbox"/> <b>Quantitative beta-hCG blood test for FCBP</b> , every 4 weeks, less than or equal to 7 days prior to the next cycle <input type="checkbox"/> <b>Other tests</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests</b>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>