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: MYBLDF

Patient RevAid ID:________

DOCTOR'S ORDERS

Ht ____________cm **Wt** ___________kg **BSA**____________m^2

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 all medications for entire cycle as written, if within 96 hours of Day 1: **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 Function** ☐ **Other Toxicity**

Proceed with treatment based on blood work from__________________________

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 25 mg, 20 mg, 15 mg, 10 mg, 5 mg, 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

STEROID (select one)*

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** PO once weekly in the morning on Days _________________ *(write in)* of each cycle

☐ **dexamethasone** ________**mg** PO once weekly in the morning on Days _________________ *(write in)* of each cycle

☐ **predniSONE** ________**mg** PO once weekly in the morning on Days _________________ *(write in)* of each cycle

☐ **No Steroid**

***Refer to Protocol for steroid dosing options**

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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PROTOCOL CODE: MYBLDF

DATE:

TREATMENT:

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

CYCLE # ______ (Cycles 1 to 8)

bortezomib ☐**1.5 mg/m²** or ☐**1.3 mg/m²** or ☐**1 mg/m²** or ☐**0.7 mg/m²** or ☐**0.5 mg/m²** (select one) x BSA =_____mg subcutaneous injection on Days 1, 8 and 15

RETURN APPOINTMENT ORDERS

For Cycles 1 to 8, book chemo on Days 1, 8, 15

☐ Return in four 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)

☐ **Urine protein electrophoresis** every 4 weeks
☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks
☐ **Beta-2 microglobulin** every 4 weeks
☐ **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
☐ **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:**