



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: UMYLDREL

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Patient RevAid ID: _____

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

<p>DOCTOR'S ORDERS DATE: _____</p> <p>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form</p> <p>Risk Category: <input type="checkbox"/> Female of Childbearing Potential (FCBP) Risk Category: <input type="checkbox"/> Male or Female of nonChildbearing Potential (NCBP)</p> <p>START DATE OF THIS CYCLE _____ Cycle # _____ START DATE OF SUBSEQUENT CYCLES _____ Cycle # _____ & _____</p> <p><input type="checkbox"/> Delay treatment _____ week(s) May 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 30 x 10⁹/L and eGFR as per protocol Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal Function <input type="checkbox"/> Other Toxicity OR Proceed with treatment based on blood work from _____</p> <p>LENALIDOMIDE One cycle = 28 days <input type="checkbox"/> lenalidomide* _____ mg PO daily, in the evening, on days 1 to 21 and off for 7 days <input type="checkbox"/> 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 <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</p> <p>STEROID*: CHOOSE ONE One cycle = 28 days <input type="checkbox"/> dexamethasone <input type="checkbox"/> 40 mg or <input type="checkbox"/> 20 mg PO once weekly, in the morning, x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> dexamethasone _____ mg PO once weekly in the morning, x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> predniSONE _____ mg PO once weekly in the morning, x <input type="checkbox"/> _____ doses OR <input type="checkbox"/> number of 28 day cycles _____ (select one) <input type="checkbox"/> No Steroid *Refer to Protocol for steroid dosing options</p> <p>Physician to assure DVT prophylaxis in place: ASA, Warfarin , low molecular weight heparin, direct oral anticoagulant or none</p>	<p>Pharmacy Use for Lenalidomide dispensing:</p> <p>Part Fill # 1 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p> <p>Part Fill # 2 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p> <p>Part Fill # 3 RevAid confirmation number: _____ Lenalidomide lot number: _____ Pharmacist counsel (initial): _____</p>
<p>Special Instructions</p>	
<p>DOCTOR'S SIGNATURE:</p> <p>Physician RevAid ID:</p>	<p>SIGNATURE:</p> <p>UC:</p>



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DATE:

RETURN APPOINTMENT ORDERS

- ☐ Return in _____ weeks for Doctor and Cycle _____
- ☐ Last cycle. Return in _____ week(s)

Laboratory:

Cycles 1-4:

CBC & Diff, Platelets, Creatinine, Calcium every two 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 5 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 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1

☐ **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: