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: UMYLENMTN

Patient RevAid ID:_____

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

DOCTOR'S ORDERS DATE: _____

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

Risk Category: ☐ **Female of Childbearing Potential (FCBP)**

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

START DATE OF THIS CYCLE _____ **Cycle #** _____

START DATE OF SUBSEQUENT CYCLES_____ **Cycle #** ____**&**____

☐ Delay treatment _____ week(s)

May 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 30 x 10^9/L and eGFR as per protocol

Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**

OR Proceed with treatment based on blood work from_____

LENALIDOMIDE

One cycle = 28 days

☐ 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 _____

MITTE: (*available as 5 mg, 10 mg, 15 mg capsules
***NB** Use one capsule for the total dose i.e., one 5 mg capsule or one 10 mg capsule or one 15 mg capsule due to budget considerations

☐ FCBP dispense Maximum 1 cycle (28 capsules for 28/28 days, 21 capsules *for 21/28 days*).

☐ For Male and Female NCBP:

Dispense_____ 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 assure DVT prophylaxis in place: ASA, Warfarin, low molecular weight heparin, direct oral anticoagulant or none

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:

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____

☐ Last cycle. Return in _____week(s)

Laboratory: Blood work done prior to next cycle must be done less than or equal to 7 days prior to the start date

Cycles 1 - 4:
CBC & Diff, Platelets, Creatinine, Calcium every two weeks

☐ **Serum Protein Electrophoresis and/or** ☐ **Serum Free Light Chain Levels** (SELECT 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** (SELECT 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: