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: UMYPOMDEX

Patient RevAid ID:_____

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

DOCTOR'S ORDERS

Ht _____**cm** **Wt** _____**kg** **BSA**_____**m²**

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

May proceed with doses as written if within **7 days** 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 per protocol**

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

Proceed with treatment based on blood work from_____

POMALIDOMIDE

One cycle = 28 days

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

☐ **pomalidomide*_____mg** po daily, in the evening, on Days 1 to 21 and off for 7 days

☐ **pomalidomide* _____ mg** po _____

(*available as 4 mg, 3 mg, 2 mg, 1 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)*

One cycle = 28 days

☐ 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 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:

DATE:

OPTIONAL CYCLOPHOSPHAMIDE:

☐ **cyclophosphamide 500 mg** PO once weekly in the morning on Days 1, 8, 15 and 22. Dispense ____ cycles.

OR

☐ **cyclophosphamide _____ mg** PO once weekly in the morning on Days _____ Dispense ____ cycles.

OR

☐ **cyclophosphamide 50 mg** PO once in the morning every 2 days for _____ doses. Dispense ____ cycles.

RETURN APPOINTMENT ORDERS

☐ Return in _____ 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 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: