

lenalidomide 25 mg - bortezomib

1.3 - dexamethasone 40 mg Regimen: Cycles 9+

ARIA Protocol Name: Len25 Bortez Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4280 0239 11 2022

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____

Cycle Duration: 28 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Hematologist
- Creatinine Clearance assessed
- LFTs and Bilirubin assessed

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- lenalidomide 25 mg PO** once daily on days 1 to 21
 - Dose modification: **lenalidomide 20 mg PO** once daily on days 1 to 21
 - Dose modification: **lenalidomide 15 mg PO** once daily on days 1 to 21
 - Dose modification: **lenalidomide 10 mg PO** once daily on days 1 to 21
 - Dose modification: **lenalidomide 5 mg PO** once daily on days 1 to 21
 - Dose modification: **lenalidomide 2.5 mg PO** once daily on days 1 to 21
- dexamethasone 40 mg PO** on day 1, 8, 15 and 22
 - Dose modification: **dexamethasone 20 mg PO** on day 1, 8, 15 and 22

This prescription is NOT eligible for medication management by dispensing pharmacist

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- acetylsalicylic acid 81 mg PO** once daily continuously while taking lenalidomide
- metoclopramide 10-20 mg PO** every 4 hours as needed
- Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.