

**pomalidomide 4 mg -
dexamethasone 40 mg Regimen**
ARIA Protocol Name: Pomalidomide - Dex
Adult Chemotherapy - Hematology Oncology
Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC5320 0342 06 2023

Weight: _____ kg

Height: _____ cm

Body Surface Area (BSA) = _____

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.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- dexamethasone 40 mg PO** on day 1, 8, 15 and 22
- Dose modification: **dexamethasone 20 mg PO** on day 1, 8, 15 and 22
- pomalidomide 4 mg PO** once daily on days 1 to 21
- Dose modification: **pomalidomide 3 mg PO** once daily on days 1 to 21
- Dose modification: **pomalidomide 2 mg PO** once daily on days 1 to 21
- Dose modification: **pomalidomide 1 mg PO** once daily on days 1 to 21

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 pomalidomide
- 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.