

**cyclophosphamide 300 -
lenalidomide 25 mg -**

dexamethasone 40 mg Regimen: Cycle 2 (Part 1)

ARIA Protocol Name: Cyclo Dex Len

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC5350 0345 05 2023

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** $80 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

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.

**cyclophosphamide 300 -
lenalidomide 25 mg -**

dexamethasone 40 mg Regimen: Cycles 2+ (Part 2)

ARIA Protocol Name: Cyclo Dex Len

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CCS350 0345 05 2023

Weight: _____ kg

Height: _____ cm

Body Surface Area (BSA) = _____

Name: _____

HCN: _____

Date of Birth: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- cyclophosphamide 300 mg/m² X BSA = _____ mg**
 - Dose modification: **cyclophosphamide 300 mg/m² X BSA - _____ % = _____ mg**
 - PO** on day 1, 8 and 15

- dexamethasone 40 mg PO** on day 1, 8, 15 and 22
 - Dose modification: **dexamethasone 20 mg PO** on day 1, 8, 15 and 22

- 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

This prescription is NOT eligible for medication management by dispensing pharmacist

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

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

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