CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pomalidomide 4 mg - cyclophosphamide 400 mg - dexamethasone 40 mg Regimen: Cycle 1 (Part 1)

ARIA Protocol Name: Pom Cyclo Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

CC5340 0344 06 2023

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 X 10^9/L and platelets **greater than or equal to** 80 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **allopurinol 300 mg PO** once daily on days 1 to 5

☐ **acetylsalicylic acid 81 mg PO** once daily continuously while taking pomalidomide

☐ **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.

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Cancer Care Program

Name:

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pomalidomide 4 mg - cyclophosphamide 400 mg - dexamethasone 40 mg Regimen: Cycle 1 (Part 2)

ARIA Protocol Name: Pom Cyclo Dex

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **cyclophosphamide 400 mg**

☐ Dose modification: **cyclophosphamide 400 mg** - _____% =_____ **mg**

PO on day 1, 8 and 15

☐ **dexamethasone 40 mg**

☐ 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 pharmacist prescribing by dispensing pharmacist

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: _____