

Doctor's Order Sheet

**lenalidomide 15 mg -
bortezomib 1.3 -
dexamethasone 40 mg -**

Regimen: Cycles 1-9 (Part I)

ARIA Protocol Name: Len Bortez Dex Lite Cycles 1-9

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4510 0261 12 2022

Name: _____

HCN: _____

Date of Birth: _____

Allergies: No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle _____ of _____ **Cycle Duration: 35 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
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

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
- acyclovir 800 mg PO** once daily until 30 days post completion of bortezomib treatment
- 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.

Doctor's Order Sheet

Name: _____
HCN: _____
Date of Birth: _____

**lenalidomide 15 mg - bortezomib
1.3 - dexamethasone 40 mg**

Regimen: Cycles 1-9 (Part II)

ARIA Protocol Name: Len Bortez Dex Lite Cycles 1-9

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- bortezomib 1.3 mg/m² X BSA = _____ mg**
 - Dose modification: **bortezomib 1.3 mg/m² X BSA - _____ % = _____ mg**
- SC on day 1, 8, 15 and 22**

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- 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 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: _____

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