

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor's Order Sheet

**lenalidomide 15 mg- bortezomib 1.3**

Regimen: Cycles 10-15 (Part I)

ARIA Protocol Name: Len Bortez Dex Lite Cycles 10-15

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4520 0262 12 2022

**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<sup>9</sup>/L and platelets **greater than or equal to** 50 X 10<sup>9</sup>/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.

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor's Order Sheet

**lenalidomide 15 mg – bortezomib 1.3**

Regimen: Cycles 10-15 (Part II)

**ARIA Protocol Name:** Len Bortez Dex Lite Cycles 10-15

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4520 0262 12 2022

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

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**bortezomib 1.3 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**

Dose modification: **bortezomib 1.3 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**

**SC** on day 1 and 15

**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

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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