

Doctor's Order Sheet

**ixazomib 4 mg -
lenalidomide 25 mg -
dexamethasone 40 mg**

Regimen (Part I)

ARIA Protocol Name: Ixazomib Lenalidomide Dexamethasone

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



CC4620 0272 01 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** $75 \times 10^9/L$, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

PREMEDICATIONS: None recommended

Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- acetylsalicylic acid 81 mg PO** once daily continuously while taking lenalidomide
- acyclovir 800 mg PO** once daily continuously during treatment and 30 days post completion of ixazomib therapy
- 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: _____

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Doctor's Order Sheet

**ixazomib 4 mg -
lenalidomide 25 mg -
dexamethasone 40 mg**

Regimen (Part II)

ARIA Protocol Name: Ixazomib Lenalidomide Dexamethasone

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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

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
- ixazomib 4 mg PO** on day 1, 8 and 15
 - Dose modification: **ixazomib 3 mg PO** on day 1, 8 and 15
 - Dose modification: **ixazomib 2.3 mg PO** on day 1, 8 and 15
- lenalidomide 25 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

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist

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Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

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