CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

lenalidomide 25 mg - dexamethasone 40 mg Regimen

ARIA Protocol Name: Len Dex

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name:

HCN:

Date of Birth:

CC4160 0227 11 2022

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

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** 50 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **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

☐ **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

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ 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.