



Doctor's Order Sheet

lenalidomide 5 mg Regimen

ARIA Protocol Name: Lenalidomide 5 MDS

Adult Chemotherapy - Hematology Oncology

Low Risk Del (5q) Myelodysplastic Syndrome (MDS)

Name: _____

HCN: _____

Date of Birth: _____



CC6060 0416 10/2023

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** $0.5 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Hematologist
- LFTs and Bilirubin assessed
- Creatinine clearance assessed.

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

lenalidomide 5 mg PO once daily on days 1 to 28

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.