CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

riTUXimab-hyaluronidase 1400 mg - lenalidomide 20 mg

Regimen: Cycles 6+

ARIA Protocol Name: rituximab SC lenalidomide MZL

Adult Chemotherapy - Hematology Oncology

Marginal Zone Lymphoma

Name:

HCN:

Date of Birth:

CC8040 0624 01 2026

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, platelets **greater than or equal to** 50 X 10^9/L and absolute lymphocyte count less than 30 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

CHEMOTHERAPY (FOR SPECIALTY PHARMACY):

☐ **lenalidomide 20 mg PO** once daily on days 1 to 21 (ensure patient enrolled in managed access program)
- ☐ Dose modification: **lenalidomide 10 mg PO** once daily on days 1 to 21
- ☐ Dose modification: **lenalidomide 15 mg PO** every other day 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

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

☐ **metoclopramide 10-20 mg PO** every 4-6 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.