Name:

HCN:

Date of Birth:

CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Doctor's Order Sheet

abiraterone Regimen

ARIA Protocol Name: Abiraterone

Adult Chemotherapy- Medical Oncology

Metastatic Castration Resistant Prostate Cancer

CC2280 0099 06 2020

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:

- PSA assessed.
- CBC and differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Blood pressure assessed.
- Serum potassium assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **abiraterone 1000 mg** PO daily
- ☐ Dose modification: **750 mg** PO daily
- ☐ Dose modification: **500 mg** PO daily
- ☐ Dose modification: **250 mg** PO daily

☐ **prednisone 5 mg** PO bid

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.