CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

darolutamide Regimen

ARIA Protocol Name: darolutamide maintenance

Adult Chemotherapy - Medical Oncology

Non-Metastatic Castration Resistant Prostate Cancer

CC6300 0440 01 2024

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: 90 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- Blood pressure assessed.
- PSA assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **darolutamide 600 mg PO** bid
  ☐ Dose modification: **darolutamide 300 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: _____