

Name: _____

HCN: _____

Date of Birth: _____

Doctor's Order Sheet

darolutamide 600 mg Regimen

ARIA Protocol Name: darolutamide - Compassionate - Prostate

Adult Chemotherapy - Medical Oncology

Metastatic Castration-Sensitive Prostate Cancer Therapy



CC4960 0306 04 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: 30 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- PSA reviewed.
- Blood pressure 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: _____

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