CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

darolutamide 600 mg - DOCEtaxel 75

Regimen: (Part I)

ARIA Protocol Name: Docetaxel 75 Darolutamide 600

Adult Chemotherapy - Medical Oncology

Metastatic Castration-Sensitive Prostate Cancer Therapy

CC7830 0603 10/2025

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

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- PSA reviewed.
- Blood pressure assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 8 mg PO** bid for 3 days, starting one day prior to DOCEtaxel. Patient must receive a minimum of three doses prior to receiving treatment.

☐ 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

darolutamide 600 mg - DOCEtaxel 75 Regimen

Regimen: (Part II)

ARIA Protocol Name: Docetaxel 75 Darolutamide 600

Adult Chemotherapy - Medical Oncology

Metastatic Castration-Sensitive Prostate Cancer Therapy

CC7830 0603 10/2025

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **DOCEtaxel 75 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **DOCEtaxel 75 mg/m²** X BSA - _____% = _____ **mg**

IV in 250 normal saline PVC Free over 60 minutes on day 1

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **darolutamide 600 mg PO bid** on days 1 to 21 continuously

☐ Dose modification: **darolutamide 300 mg PO bid** on days 1 to 21 continuously

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: _____