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: Docetaxel75 Darolutamide600 Compassionate

Adult Chemotherapy - Medical Oncology

Metastatic Castration-Sensitive Prostate Cancer Therapy

CC4600 0270 01 2023

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 or equal to** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
  - Bilirubin < or = to ULN
  - AST/ALT < or = to 1.5 x ULN
  - ALP < 2.5 x ULN
- Creatinine clearance assessed. Creatinine clearance > 30 mL/min (for darolutamide)

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.

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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: Docetaxel75 Darolutamide600 Compassionate Adult Chemotherapy - Medical Oncology

Metastatic Castration-Sensitive Prostate Cancer Therapy

CC4600 0270 01 2023

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **DOCEtaxel 75 mg/m^2** X BSA **= _____ mg**

☐ Dose modification: **DOCEtaxel 75 mg/m^2** X BSA - _____% = _____ **mg**

IV in 250 to 500 mL normal saline PVC Free over 60 minutes on day 1

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: _____