

PROTOCOL CODE: UGUPAJABI

| DOCTOR'S ORDERS | |
|---|---------------------|
| Continuous treatment, one cycle consists of 4 weeks of abiraterone and corticosteroid | |
| REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form | |
| DATE: | To be given: |
| Cycle #: | |
| Date of Previous Cycle: _____ | |
| <input type="checkbox"/> Delay treatment _____ week(s) Dose modification for: <input type="checkbox"/> Total bilirubin/ALT and potassium parameters _____ (refer to protocol) <input type="checkbox"/> Toxicity _____ Proceed with treatment based on blood work from _____ | |
| TREATMENT: | |
| abiraterone 1000 mg PO once daily | |
| Dose modification: abiraterone <input type="checkbox"/> 750 mg OR <input type="checkbox"/> 500 mg OR <input type="checkbox"/> 250 mg PO once daily (select one). | |
| Mitte: 30 days (for Cycles 1 to 3). | |
| Mitte: 90 days (for Cycles 4 onwards). Repeat: _____ | |
| predniSONE <input type="checkbox"/> 5 mg PO twice daily or <input type="checkbox"/> 10 mg PO daily or <input type="checkbox"/> 5 mg PO daily (select one) | |
| Mitte: 30 days (for Cycles 1 to 3). | |
| Mitte: 90 days (for Cycles 4 onwards). Repeat: _____ | |
| *Corticosteroid Dosing Option: dexamethasone <input type="checkbox"/> 1.5 mg PO daily or <input type="checkbox"/> 0.5 mg PO daily (select one) | |
| Mitte: 30 days (for Cycles 1 to 3). | |
| Mitte: 90 days (for Cycles 4 onwards). Repeat: _____ | |
| RETURN APPOINTMENT ORDERS | |
| For Cycles 1 to 3: <input type="checkbox"/> Return in 4 weeks for Doctor and Cycle _____ For Cycles 4 onwards: <input type="checkbox"/> Return in 12 weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s). | |
| Cycles 1 to 3: CBC & Diff, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, random glucose, sodium, potassium, PSA every 4 weeks Cycles 1 to 3: potassium, ALT, alkaline phosphatase, total bilirubin every 2 weeks Cycles 4 onwards: CBC & Diff, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, random glucose, sodium, potassium, PSA, testosterone prior to each physician visit If clinically indicated: <input type="checkbox"/> total protein <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> LDH <input type="checkbox"/> TSH <input type="checkbox"/> calcium <input type="checkbox"/> MUGA scan or <input type="checkbox"/> Echocardiography (if clinically indicated) <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests. | |
| DOCTOR'S SIGNATURE: | SIGNATURE: |
| | UC: |