Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: UGUMCSPDD

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**_____

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, platelets** day of treatment

For Cycles 1 to 6: May proceed with DOCEtaxel as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than 90 x 10^9/L** and (if ordered), **total bilirubin less than or equal to ULN, alkaline phosphatase less than 2.5 x ULN (unless bone metastases), and ALT less than or equal to 1.5 x ULN**

For Cycles 1 to 6: May proceed with darolutamide if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L,** and **platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

dexamethasone 8 mg PO bid for 3 days, starting one day prior to DOCEtaxel; **patient must receive a minimum of 3 doses pretreatment**

Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

☐ **CYCLES 1 to 6** (DOCEtaxel and darolutamide combination treatment)

DOCEtaxel 75 mg/m² x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over one hour (use non-DEHP tubing)

darolutamide 600 mg PO twice daily.

Dose modification:

☐ **darolutamide 300 mg** PO twice daily.

Mitte:_____ days (maximum 90 days). Repeat x _____

Remember to commence standard **androgen deprivation therapy** (i.e., LHRH agonist, LHRH antagonist)

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DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:

TREATMENT, continued:

☐ **CYCLES 7 onwards** (darolutamide treatment)

darolutamide 600 mg PO twice daily.

Dose modification:

☐ **darolutamide 300 mg** PO twice daily.

Mitte:_____days (maximum 90 days). Repeat x _____

Remember to continue standard **androgen deprivation therapy** (i.e., LHRH agonist, LHRH antagonist)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Return in _____ weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

Cycles 1 to 6 (DOCEtaxel and darolutamide combination treatment): **CBC & Diff, platelets and PSA** prior to each cycle

☐ Prior to Cycle 4 and as clinically indicated for Cycles 1 to 6: **ALT, alkaline phosphatase, total bilirubin, LDH**

Cycles 7 onward (darolutamide treatment): **PSA, testosterone** prior to each physician visit

If clinically indicated for Cycles 7 onward:

☐ **ECG** ☐ **calcium** ☐ **albumin** ☐ **total bilirubin** ☐ **ALT** ☐ **INR**
☐ **random glucose** ☐ **HbA1c** ☐ **creatinine** ☐ **sodium** ☐ **potassium**
☐ **TSH**

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: