

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: UGUPENZ

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

DOCTOR'S ORDERS	
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) Proceed with treatment based on bloodwork from _____	
TREATMENT:	
<input type="checkbox"/> enzalutamide 160 mg PO once daily. Mitte: 90 days. Repeat x _____ Dose Modification:	
<input type="checkbox"/> enzalutamide 120 mg PO once daily. Mitte: 90 days. Repeat x _____	
<input type="checkbox"/> enzalutamide 80 mg PO once daily. Mitte: 90 days. Repeat x _____	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____.	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
PSA, testosterone prior to each physician visit If clinically indicated: <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> creatinine <input type="checkbox"/> ECG <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: