PROTOCOL CODE: GUPADT

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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

DATE:

TREATMENT:

Patient will be receiving injections via: (select one option)

- ☐ **Manufacturer home injection program**
- ☐ **BC Cancer regional center**
- ☐ **Alternate healthcare provider**
- ☐ **Community Oncology Network (CON) site**

Choose one of the injection options below:

goserelin long acting (ZOLADEX) ☐ **3.6 mg** subcutaneous every month x _____doses

goserelin long acting (ZOLADEX LA) ☐ **10.8 mg** subcutaneous every 3 months x _____doses

OR

leuprolide long acting (LUPRON DEPOT) ☐ **7.5 mg** IM every month x _____doses

leuprolide long acting (LUPRON DEPOT) ☐ **22.5 mg** IM every 3 months x _____doses

leuprolide long acting (LUPRON DEPOT) ☐ **30 mg** IM every 4 months x _____doses

OR

leuprolide long acting (ELIGARD) ☐ **7.5 mg** subcutaneous every month x _____doses

leuprolide long acting (ELIGARD) ☐ **22.5 mg** subcutaneous every 3 months x _____ doses

leuprolide long acting (ELIGARD) ☐ **30 mg** subcutaneous every 4 months x _____ doses

leuprolide long acting (ELIGARD) ☐ **45 mg** subcutaneous every 6 months x _____ doses

OR

degarelix ☐ **240 mg** subcutaneous (as two injections of 120 mg) loading dose on day 1

☐ **80 mg** subcutaneous (single injection) every month x _____ doses

Injections to be given in abdominal region. To reduce incidence of injection site reactions, withdraw needle from patient 30 seconds post injection.

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

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DATE:

TREATMENT: (continued)

If required, choose one of the oral options below:

☐ **bicalutamide 50 mg** PO daily

☐ **flutamide 250 mg** PO TID

Supply for: _____ days. Repeat x _____

RETURN APPOINTMENT ORDERS

☐ Return in _____ months for Doctor.

If clinically indicated:

☐ **PSA** ☐ **testosterone**

For patients taking flutamide, every 3 months:

☐ **total bilirubin** ☐ **ALT** ☐ **alkaline phosphatase**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: