



Provincial Health Services Authority

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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

## PROTOCOL CODE: UGUPAJENZ

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

DOCTOR'S ORDERS	
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>	
<b>DATE:</b>	<b>To be given: Cycle #:</b>
Date of Previous Cycle:	
<input type="checkbox"/> Delay treatment _____ week(s)	
Proceed with treatment based on bloodwork from _____	
<b>TREATMENT:</b>	
<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 _____	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____.	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<b>PSA</b> 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"/> testosterone	
<input type="checkbox"/> Other tests:	
<input type="checkbox"/> Consults:	
<input type="checkbox"/> See general orders sheet for additional requests.	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>