Hospital Information (including name, address, telephone number)

Clinic information (including clinic name and telephone number)

Patient information (including name, address, date of birth, phone number)

Allergies (*also specify reaction*) ☐ None known

Patient Name _____

DGRL (degarelix)

Diagnosis: Prostate Cancer

Rx (Start date: _____)

Loading Dose

□ degarelix 240 mg subcutaneous injection on Day 1 of Month 1 (2 x 120 mg injections)

Maintenance dose (begin one month after starting dose):

□ degaralix 80mg subcutaneous injection once monthly

Mitte: _____ x 120mg injection and/or _____ x 80mg injection (ODB general benefit)

Repeat:_____

Supportive Care Rx

The recommended daily doses are 1200 mg of elemental calcium and 800 IU of Vitamin D

□ calcium supplements _____

□ Vitamin D supplements _____

_____ _____ _____ _____

Date Print name Physician Signature CPSO#

Prescriber information (name, office phone number/fax, address if different than hospital address)
Pharmacist information (name, office phone number/fax)

Developed by the Drug Formulary Team at Cancer Care Ontario.
Format and content have been adapted with permission
from Mount Sinai Hospital
DGRL - Version 1.0

Ontario
Cancer Care Ontario
Action Cancer Ontario

OPTIONAL INFORMATION

□ Patient has been counseled by an Oncology Pharmacist

_____	_____	_____
Print name	Signature	Date

OR

□ Requires counseling
□ Drug interaction assessment

Drug-specific information

For the complete information, please refer to the Cancer Care Ontario drug information sheets available at www.cancercare.on.ca/drugformulary

Developed by the Drug Formulary Team at Cancer Care Ontario.
Format and content have been adapted with permission
from Mount Sinai Hospital
DGRL - Version 1.0

Ontario
Cancer Care Ontario
Action Cancer Ontario