SUPPLEMENTARY INFORMATION

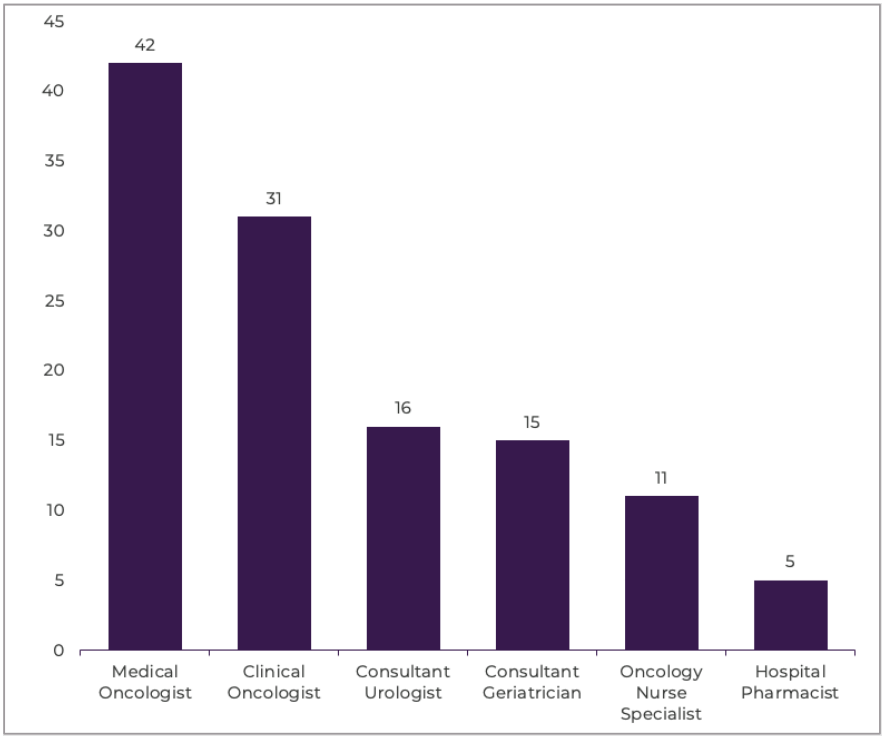

Figure S1. Occupational distribution of respondents

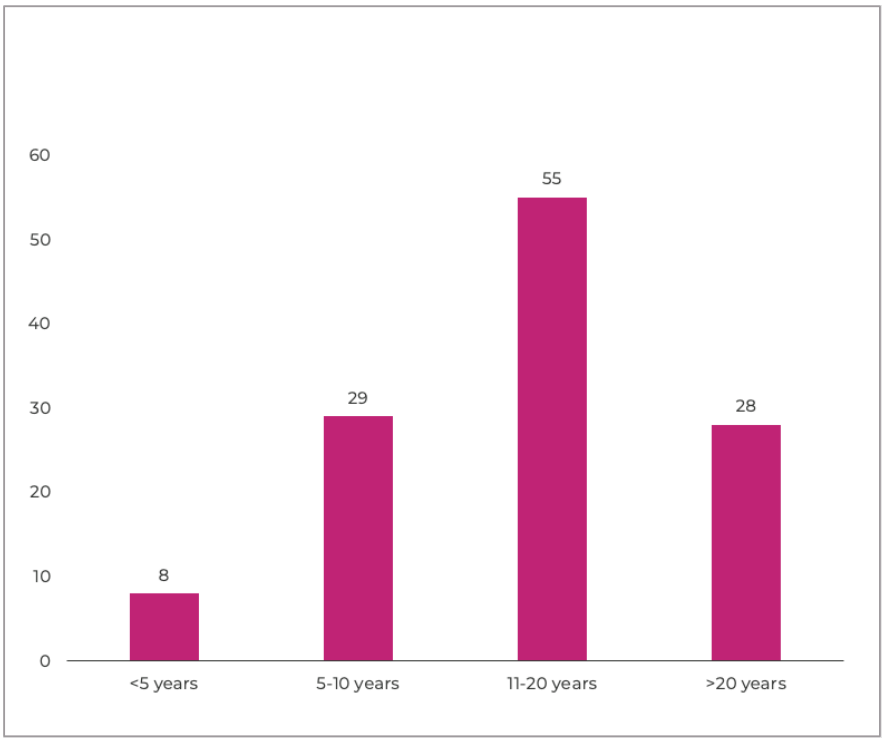

Figure S2. Distribution of respondents in the UK by time in role

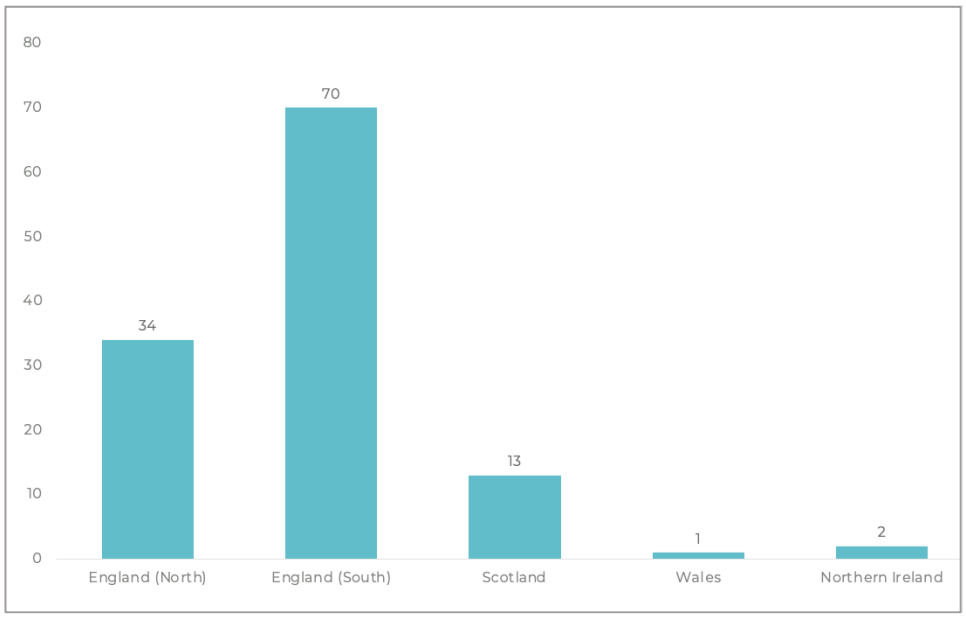

Figure S3. Distribution of respondents based on the UK region

Figure S4. Agreement levels for each statement. For legibility all percentage labels below 5% have been removed.

Table S1. Consensus statements which showed a difference of ≥10% variation above or below the overall agreement achieved, as analysed by role. Differences of +≥10% are highlighted in pink, and -≥10% are highlighted in blue

No:	Statement:	Total n=120	Medical Oncologist n=42	Clinical Oncologist n=31	Consultant Urologist n=16	Consultant Geriatrician n=15	Oncology Nurse Specialist n=11	Hospital Pharmacist n=5
3	The evidence for treatment intensification in mHSPC with ADT + ARTA + chemotherapy is based on ARASENS	89%	88%	94%	81%	73%	91%	100%
8	If a patient is offered treatment with docetaxel, then it should be in the context of triplet therapy (ADT + ARTA + Chemotherapy)	83%	83%	84%	56%	93%	100%	80%
11	Treatment intensification is not associated with significant impact to quality of life at 1 year in clinical trials compared to the comparator arms	73%	76%	68%	69%	60%	82%	60%
13	Most patients should be assessed with a comprehensive multidisciplinary assessment (such as the comprehensive geriatric assessment) to identify suitability for treatment intensification with triplet therapy	86%	79%	74%	94%	93%	82%	80%
22	Triplet therapy should be considered in patients with low volume disease that has a significant disease burden (e.g., with multiple lymph node involvement) who are suitable for chemotherapy	73%	64%	61%	93%	81%	55%	100%
25	All newly diagnosed mHSPC patients suitable for triple therapy should be offered it	82%	74%	74%	87%	94%	64%	100%

Table S2. Consensus statements which showed a difference of ≥10% variation above or below the overall agreement achieved, as analysed by region. Differences of +≥10% are highlighted in pink, and -≥10% are highlighted in blue

No:	Statement:	Total n=120	England (North) n=34	England (South) n=70	Scotland n=13	Wales n=1	Northern Ireland n=2
12	In metastatic disease a patient's prostate cancer is likely to be a determining factor of reduced life expectancy, and treatment intensification with triplet therapy should be considered	92%	94%	94%	77%	100%	50%
18	Tools such as G8, Charlson comorbidity index (CCI), frailty scores should be utilised in appropriate patients	88%	88%	89%	92%	100%	50%
19	Triplet therapy should be considered in fitter patients e.g., ECOG 0-1	93%	100%	96%	69%	100%	50%
20	Triplet therapy should be considered in patients with high-risk disease	92%	97%	94%	62%	100%	100%
21	Triplet therapy should be the preferred option in patients with high volume disease who are suitable for chemotherapy, as defined by CHAARTED	94%	100%	99%	62%	100%	50%

22	Triplet therapy should be considered in patients with low volume disease that has a significant disease burden (e.g., with multiple lymph node involvement) who are suitable for chemotherapy	**73%**	76%	79%	**38%**	**100%**	**50%**
23	Triplet therapy should be the preferred option in patients with visceral disease (liver or lung metastases) who are suitable for chemotherapy	**88%**	88%	91%	**69%**	**100%**	**100%**
24	Approximately 30% of newly diagnosed mHSPC patients are potentially suitable for treatment intensification with triplet therapy	**88%**	97%	87%	**69%**	**100%**	**50%**
25	All newly diagnosed mHSPC patients suitable for triple therapy should be offered it	**82%**	85%	86%	**46%**	**100%**	**100%**