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)

Patient Name _____

Allergies (*also specify reaction*) ☐ None known

## ABIRPRED (abiraterone-predniSONE)

## Diagnosis: Prostate Cancer

### Clinical Verification

□ Bloodwork and other clinical parameters have been verified by a regulated health professional

_____ Date _____ Print name _____ Signature

□ Prescription has been verified by an nurse or pharmacist

_____ Date _____ Print name _____ Signature

### Rx (Start date: _____)

abiraterone** 1000 mg x ___% dose* =_____mg PO daily

Mitte: _____ x 250 mg tablets □ EAP approved (if applicable)

**AND**

predniSONE 10 mg x ____% dose*=_____mg PO daily

Mitte:_____ x 5 mg tablets

**Dose modification for: □ Age/performance status □ Renal function □ Hepatic function □ Other: _____*
***continue GnRH agonist if no prior orchidectomy*

**NO Repeats**

_____ 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)





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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](www.cancercare.on.ca/drugformulary)*





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