AFAT (afatinib)

**Diagnosis:** Non-small Cell Lung 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 a nurse or pharmacist
  - Date
  - Print name
  - Signature

**Rx (Start date: ___________)**
- afatinib 40 mg PO daily on an empty stomach (Standard dose) or
- afatinib 30 mg* PO daily on an empty stomach or
- afatinib 20 mg* PO daily on an empty stomach
  - Mitte: _____ x 40 mg tablets or _____ x 30 mg tablets or _____ x 20 mg tablets
- EAP approved (if applicable)
- *Dose modification for: □ Age/performance status □ Renal function □ Hepatic Impairment □ Diarrhea
  □ Dermatological events □ Other: ___________

**NO Repeats**

**Supportive Care Rx**
- loperamide 4 mg at the first sign of diarrhea, then 2 mg after every loose bowel movement PRN
  - Mitte: _____ Repeat: _____ LU 113
- minocycline 100 mg BID for rash
  - Mitte: _____ Repeat: _____
- hydrocortisone 1% cream apply to affected area BID PRN for rash
  - Mitte: _____ Repeat: _____

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)
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