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

AXIT (axitinib)

Diagnosis: Renal Cell 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: _____)

Starting dose:

□ axitinib 5 mg x ____% dose* = _____ mg PO BID

OR Titrated dose:

□ axitinib 10 mg x ____% dose*=_____ mg PO BID

Mitte: _____ x 5 mg tablets and/or _____x 1 mg tablets □ EAP approved (if applicable)

**Dose modification for: □ Age/performance status □ Proteinuria □ Hypertension □ Renal function □ Hepatic function □ Other*_____

NO Repeats

Supportive Care Rx

□ Antihypertensive (if applicable, specify drug, dose, frequency):_____

Mitte: ____ Repeat: ____ □ LU Code _____ OR □ EAP approved (if applicable)

_____ 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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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

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