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 _____

BICABSRL (bicalutamide-buserelin)

Diagnosis: Prostate Cancer

Rx (Start date: _____)

bicalutamide 50 mg PO daily

Mitte: _____ (ODB general benefit) Repeat :_____

AND (check appropriate dose):

□ buserelin 6.3 mg subcutaneous injection every 2 months

OR

□ buserelin 9.45 mg subcutaneous injection every 3 months

Mitte: _____ (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
BICABSRL - 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
BICABSRL - Version 1.0

Ontario
Cancer Care Ontario
Action Cancer Ontario