

Hospital information (including name, address, telephone number)

Patient information (including name, address, date of birth, phone number)

Clinic information (including clinic name and telephone number)

Allergies (*also specify reaction*)

None known

Patient Name _____

BICAGOSE (bicalutamide-goserelin)

Diagnosis: Prostate Cancer

Rx (Start date: _____)

bicalutamide 50 mg PO daily

Mitte: _____ (ODB general benefit) Repeat: _____

AND (check appropriate dose):

goserelin 3.6 mg subcutaneous injection every 4 weeks *or*

goserelin 10.8mg subcutaneous injection every 13 weeks

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)

OPTIONAL INFORMATION

- Patient has been counseled by an Oncology Pharmacist

OR

_____	_____	_____
Print name	Signature	Date

- 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