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

FC(PO)+/-R (**fludarabine-cyclophosphamide**+/- *riTUXimab*)*
**drug in italics is IV drug given in hospital or cancer centre*

Diagnosis: Non-Hodgkin's Lymphoma (NHL)

Cycle #: _____; Cycles repeat every 28 days
Height = ________ cm Weight = _________ kg
Body Surface Area (BSA) = _________ m^2

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/Day 1: _____________)

fludarabine 24 - 25 mg/m^2 x BSA x ____% dose* = ______ mg PO daily on Days 1 to 5

Mitte: ____ x 10 mg tablets **NO Repeats** (No LU Code for this indication)

cyclophosphamide 150 mg/m^2 x BSA x ____% dose* = ______ mg PO daily on Days 1 to 5

Mitte: ____ x 25 mg tablets and/or ___ x 50 mg tablets **NO Repeats** (ODB general benefit)

**Dose modification for: □ Age/performance status □ Hematologic toxicity □ Hepatic function □ Renal function □ Other __________*

Supportive Care Rx

□ 5-HT_3 receptor antagonist (centre choice) pre-chemotherapy on Day(s) ____
Mitte: _______ Repeat:____ □ LU Code ________

□ dexamethasone 8mg PO pre-chemo on Day(s) _____ Mitte: _______ Repeat: ____

□ prochlorperazine 10 mg PO q6h PRN nausea Mitte: _______ Repeat: ____

□ G-CSF support (if applicable): ___________________________________ Mitte: _______ Repeat: ____

□ PJP prophylaxis (if applicable): ___________________________________ Mitte: _______ Repeat: ____

□ Shingles prophylaxis (if applicable): ___________________________________ 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)

Developed by the Drug Formulary Team at Cancer Care Ontario.
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Cancer Care Ontario
Action Cancer Ontario

SAMPLE

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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