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

## FLVS (fulvestrant)

## Diagnosis: Breast Cancer

## Rx (Start date/Day 1: ____________)

**Loading dose:**

□ fulvestrant 500 mg intramuscular injection on Days 1, 15, 29

Mitte: _________

**THEN Maintenance dose:**

□ fulvestrant 500 mg intramuscular injection every 4 weeks

Mitte: _________ 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)



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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](http://www.cancercare.on.ca/drugformulary)*

SAMPLE



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