IBRU (ibrutinib)

Diagnosis: Chronic Lymphocytic Leukemia (CLL)

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: ___________

ibrutinib 420 mg x _____% dose* = _____mg PO daily

Mitte: _____ x 140mg capsules

*Dose modification for: □ Hematologic toxicity □ Hepatic function □ Renal function □ Other: ___________

NO Repeats

Supportive Care Rx

☐ prophylaxis for tumour lysis syndrome, if applicable (specify drug, dose, frequency):

________________________________________________________________________ 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)
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