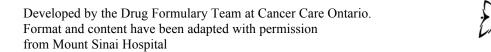
	,
Hospital Information (including name, address, telephone number)	Patient information (including name, address, date of birth, phone number)
Clinic information (including clinic name and telephone number)	
Allergies (also specify reaction)	Patient Name
IMAT (imatinib)	
Diagnosis: Chronic Myelogenous Leukemia (CML)	
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:)	
□ imatinib 600mg PO daily <i>or</i>	
□ imatinib 400mg PO BID <i>or</i>	
□ imatinib 400mg x% dose* =mg PO daily	
Mitte: (Available as 100 mg and 400 mg table	ets) (ODB general benefit)
*Dose modification for:   Age/performance status   Rena  Other	al function □ Hepatic function □ Rash
NO Repeats	
Date Print name Physician Sig	gnature CPSO#
Prescriber information (name, office phone number/fax, adepharmacist information (name, office phone number/fax)	dress if different than hospital address)



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## **OPTIONAL INFORMATION**

]	Patient has been counseled by an Oncology Pharmacist		
)R	Print name	Signature	Date
I	Requires counseling Drug interaction assessment	i	

Drug-specific information

For the complete information, please refer to the Cancer Care Ontario drug information sheets available at www.cancercare.on.ca/drugformulary



