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)

Allergies (*also specify reaction*) ☐ None known

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 *or*

□ imatinib 400mg PO BID *or*

□ imatinib 400mg x _____% dose* = _____mg PO daily

Mitte: _____ (Available as 100 mg and 400 mg tablets) (ODB general benefit)

**Dose modification for:* □ *Age/performance status* □ *Renal function* □ *Hepatic function* □ *Rash* □ *Other* _____

NO Repeats

_____ 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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Cancer Care Ontario
Action Cancer Ontario

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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