

COMMUNITY PHARMACIST LIAISON FORM

Initiating pharmacological treatment for
oropharyngeal mucositis in a patient receiving
cancer therapy

No. 888029

Collective prescription number (if applicable):

Institution:

PATIENT IDENTIFICATION

Last name:

First name:

Date of birth:

Health insurance number:

PHARMACY (OR PHARMACIST) IDENTIFICATION

NAME:

TELEPHONE NUMBER:

FAX NUMBER:

This form is the original. The pharmacy (or pharmacist) whose name appears above is the only recipient. The original of this form will not be reused.

DRUG IDENTIFICATION AND DOSAGE

☐ **First-line oncology mouthwash**

Diphenhydramine	250 ml elixir (12.5 mg/5 ml) or capsules (12.5 x 50 mg)
Hydrocortisone	100 mg powder or tablets (10 x 10 mg or 5 x 20 mg)
Magnesium/aluminium hydroxide	165 ml oral suspension (200-200 mg/5 ml)
Nystatin	62 ml oral suspension (100,000 U/ml)
Sterile water	q.s. to 500 ml

Dosage: 15 to 30 ml QID until symptom resolution

Stability: 14 days in refrigerator

☐ **Oncology mouthwash with lidocaine**

Diphenhydramine	200 ml elixir (12.5 mg/5 ml) or capsules (10 x 50 mg)
Viscous lidocaine	200 ml 2% oral topical gel
Magnesium/aluminium hydroxide	200 ml oral suspension (200-200 mg/5 ml)
Sterile water	q.s. to 600 ml, if necessary

Dosage: 15 to 30 ml QID until symptom resolution

Stability: 14 days in refrigerator

*For additional information, consult Québec national medical protocol No. 888029 on INESSS's [website](#).

IDENTIFICATION OF THE HEALTH PROFESSIONAL WHO EXECUTES THE PRESCRIPTION

Name, Surname:

Practice license number:

Telephone number:

Signature:

Date:

PRESCRIBING PHYSICIAN IDENTIFICATION

Name, Surname:

Practice license number:

Telephone number:

FAX TRANSMITTAL TO COMMUNITY PHARMACY

(to be completed only if the sender is different from the authorized professional)

Sender's Name:

Date and time fax sent: