

Form A120: Physician Prescription – Study Drugs A and B

INSTRUCTIONS: A trial nurse/coordinator may complete this form; however, it must be signed by a trial physician or nurse with prescription writing privileges. FAX/Send form to PHARMACY if drug is being dispensed.

Section A: KEY IDENTIFYING INFORMATION

- A1. Study Identification Number _____ - _____ - _____ - _____ - _____
- A2. Study drug assigned STUDY DRUG A..... 1 (A3a)
STUDY DRUG B.....2 (A3b)
- A3. Type of cycle
- | a. STUDY DRUG A | b. STUDY DRUG B |
|--------------------------------------|---------------------------------------|
| CYCLE 1a.....0 | CYCLE 1..... 1 |
| CYCLE 1b.....1 | CYCLE 2..... 2 |
| CYCLE 2.....2 | CYCLE 3..... 3 |
| CYCLE 3.....3 | DOWN-TITRATION..... 5 |
| CYCLE 4.....4 | MAINTENANCE: START or REFILL..... 6 |
| DOWN-TITRATION.....5 | MAINTENANCE: DOSE CHANGE ONLY 7 |
| MAINTENANCE: START or REFILL.....6 | |
| MAINTENANCE: DOSE CHANGE ONLY7 | |
- A4. Date of form completion _____ / _____ / _____
M M / D D / Y Y Y Y
- A5. Name of person completing form _____
PRINT FULL NAME INITIALS

Section B: STUDY DRUG INFORMATION

- B1. Prescription number _____
- B2. Date of prescription _____ / _____ / _____
M M / D D / Y Y Y Y
- B3. Subject weight _____ . _____ kg
- B4. Dose prescribed _____ . _____ mg/kg (*Enter '-5' if subject taking MAX dose of study drug*)
- B5. Study drug preparation SUSPENSION 1 PILL 2

Medication Dispensing Worksheet – <u>SUSPENSION</u>			
Dose prescribed	X	Subject weight	= Dose to administer
_____ . _____ mg/kg		_____ . _____ kg	_____ mg/day (round to nearest 1 mg)

Medication Dispensing Worksheet – <u>PILLS</u>			
Dose prescribed	X	Subject weight	= Dose to administer
_____ . _____ mg/kg		_____ . _____ kg	_____ . _____ mg/day (round to nearest 12.5 mg)

- B6. Study drug administration DAILY 1
TWICE A DAY (b.i.d)..... 2
- B7. Dose to administer per day _____ . _____ mg/day
- B8. Number of days in prescription _____ days
- a. Is drug being dispensed for this prescription? YES..... 1 NO 2
- B9. Name and signature of prescribing investigator _____
PRINT FULL NAME SIGNATURE DATE

Section Z: TIME TO COMPLETE FORM

- Z1. How long did it take to complete this form? _____ minutes

END OF FORM