CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

methotrexate 20 mg Regimen:

ARIA Protocol Name: Methotrexate PO Weekly – Mycosis Fungoides

Adult Chemotherapy - Hematology Oncology

Non Hodgkins Lymphoma – Mycosis Fungoides

CC5900 0400 09 2023

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **folic acid 5 mg PO** once daily for 6 days every week (DO NOT take on methotrexate days)

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **methotrexate 20 mg PO** on days 1, 8, 15 and 22

☐ Dose modification: **methotrexate** _____ **mg PO** on days 1, 8, 15 and 22

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.