CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

methotrexate 1 mg/kg Regimen

ARIA Protocol Name: methotrexate 1 mg/kg
Adult Chemotherapy - Gynecological Oncology
Low Risk Gestational Trophoblastic Cancer Therapy

CC6470 0457 02 2024

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

Allergies: ☐ **No Known**

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

Cycle_____ of _____ **Cycle Duration: 14 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine Clearance assessed.
- Serum beta hCG levels assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **methotrexate 1 mg/kg** X weight (kg) **=** _____ **mg**

☐ Dose modification: **methotrexate 1 mg/kg** X weight (kg) - _____% = _____ **mg**

IM on days 1, 3, 5 and 7

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **leucovorin calcium 15 mg PO** daily on days 2, 4, 6 and 8

Take 30 hours after each methotrexate dose

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.