CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

PRALAtrexate 10/20/30

Regimen: Cycle I (Part I)

ARIA Protocol Name: PRALAtrexate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Peripheral T-cell Lymphoma

Name:

HCN:

Date of Birth:

CC6790 0499 07/2024

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** 1.0 X 10^9/L and platelets **greater than or equal to** 50 X 10^9/L, otherwise notify Hematologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **folic acid 1 mg PO** once daily

Starting at least 10 days before the first dose of PRALAtrexate, continue during treatment and for 30 days after last PRALAtrexate dose

☐ **cyanocobalamin 1000 mcg IM** every 8 weeks

Administer the first dose within 10 weeks prior to first PRALAtrexate dose and continue every 8 weeks during treatment. After first dose, subsequent doses may be administered on the same day as PRALAtrexate

☐ Other: _____

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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

PRALAtrexate 10/20/30

Regimen: Cycle I (Part II)

ARIA Protocol Name: PRALAtrexate

Adult Chemotherapy - Hematology Oncology

Relapsed or Refractory Peripheral T-cell Lymphoma

Name:

HCN:

Date of Birth:

CC6790 0499 07/2024

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **PRALAtrexate 10 mg/m^2** X BSA = _____ **mg**

☐ Dose modification: **PRALAtrexate 10 mg/m^2** X BSA - _____% = _____ **mg**

IV push on **day 1** (round to nearest 1 mg)

☐ **PRALAtrexate 20 mg/m^2** X BSA = _____ **mg**

☐ Dose modification: **PRALAtrexate 20 mg/m^2** X BSA - _____% = _____ **mg**

IV push on **day 8** (round to nearest 1 mg)

☐ **PRALAtrexate 30 mg/m^2** X BSA = _____ **mg**

☐ Dose modification: **PRALAtrexate 30 mg/m^2** X BSA - _____% = _____ **mg**

IV push on **day 15** (round to nearest 1 mg)

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **leucovorin calcium 15 mg PO** twice daily on days 3 to 6, 10 to 13, and 17 to 20

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist.

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **metoclopramide 10-20 mg PO** every 4 to 6 hours as needed

☐ Other: _____

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.