



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: LYPRA

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: _____ **To be given:** _____ **Cycle #:** _____

Date of Previous Cycle: _____

- Delay treatment _____ week(s)
- CBC & Diff, Platelets** day of treatment

May proceed with doses as written Day 1 if within 96 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L, bilirubin and creatinine less than or equal to 3 x upper limit of normal**
 May proceed with Day 8 and 15 doses if within 24 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L**

Dose modification for: **Hematology** **Other Toxicity:** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
 Ensure patient is taking **follic acid** and has had **vitamin B12** injection starting at least 10 days prior to first cycle, and to continue while on treatment, until 30 days after last pralatrexate dose.
 Other: _____

CHEMOTHERAPY:

CYCLE 1:

Day 1:
pralatrexate 10 mg/m² x BSA = _____ mg
 IV push over 3 to 5 minutes

Day 8:
pralatrexate 20 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV push over 3 to 5 minutes

Day 15:
pralatrexate 30 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV push over 3 to 5 minutes

leucovorin 15 mg PO BID on Days 3 to 6, 10 to 13, 17 to 20

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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DOCTOR'S ORDERS

DATE:

CYCLE # _____

Days 1, 8, 15

pralatrexate 30 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV push over 3 to 5 minutes

leucovorin 15 mg PO BID on Days 3 to 6, 10 to 13, 17 to 20

RETURN APPOINTMENT ORDERS

Return in **four** weeks for Doctor and Cycle _____

Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH prior to each cycle

CBC & Diff, Platelets prior to Days 8 and 15

Cycles 1 and 2: Telephone nursing assessment (up to 48 hours) prior to Days 8 and 15

If required for subsequent cycles: Telephone nursing assessment prior to Days 8 and 15

vitamin B12 injection required every 8 to 10 weeks. Patient to obtain supply.

This patient to receive injection in clinic. Next injection due by _____.

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: