



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

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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** day of treatment

May proceed with doses as written Day 1 if within 96 hours **ANC greater than or equal to $1.0 \times 10^9/L$, Platelets greater than or equal to $50 \times 10^9/L$, 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 $1.0 \times 10^9/L$, Platelets greater than or equal to $50 \times 10^9/L$**

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 **folic 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/m^2 x BSA = _____ mg

IV push over 3 to 5 minutes

Day 8:

pralatrexate 20 mg/m^2 x BSA = _____ mg

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

IV push over 3 to 5 minutes

Day 15:

pralatrexate 30 mg/m^2 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, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH prior to each cycle

CBC & Diff prior to Days 8 and 15

If clinically indicated: ☐ **HBV viral load**

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: