# DOCTOR’S ORDERS

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<tr>
<th>Ht</th>
<th>Wt</th>
<th>BSA</th>
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**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** $1.0 \times 10^9/L$, **Platelets greater than or equal to** $50 \times 10^9/L$, **bilirubin and creatinine less than or equal to** $3 \times$ 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/m$^2$ x BSA = ________ mg
    - IV push over 3 to 5 minutes

**Day 15:**
- pralatrexate 30 mg/m$^2$ x BSA = ________ mg
  - [ ] Dose Modification: ________ mg/m$^2$ 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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<td>CYCLE # _______</td>
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<tr>
<td>Days 1, 8, 15</td>
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<tr>
<td>pralatrexate 30 mg/m² x BSA = _________ mg</td>
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<td>□ Dose Modification: _________ mg/m² x BSA = _________ mg</td>
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## 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: |