PROTOCOL CODE: SANAHDMAP (inpatient)

Cycles 1 to 4, Weeks 4 and 5: methotrexate

Cycles 5 to 6, Weeks 3 and 4: methotrexate

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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

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

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

May proceed with methotrexate and leucovorin doses as written if within 48 hours **ANC greater than or equal to 0.25 x 10^9/L, platelets greater than or equal to 50 x 10^9/L, creatinine clearance greater than or equal to 60 mL/min, and urine pH greater than or equal to 7**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

INPATIENT TREATMENT

- Admit to inpatient bed
- Daily weights, intake / output
- Refer to inpatient ward policies and procedures for additional orders (e.g., routine vital signs, VTE prophylaxis, etc.)

ON ADMISSION:

CBC & Diff, sodium, potassium, creatinine, calcium, magnesium, albumin, total bilirubin, alkaline phosphatase, ALT, LDH, GGT prior to Day 1

chest x-ray prior to each methotrexate dose

urine pH immediately pre-methotrexate

urine pH q6H until methotrexate levels less than 0.1 micromol/L

creatinine, sodium, potassium every morning during methotrexate treatment and continued until methotrexate levels less than 0.1 micromol/L (starting morning after each methotrexate dose i.e., starting on Day 2)

methotrexate levels at hour 48 from start of methotrexate infusion, or morning of Day 3 (methotrexate given on Day 1) then once daily every morning until methotrexate levels less than 0.1 micromol/L

- Note date and time of withdrawal as well as start time of infusion on specimen
- MD to be notified of all results immediately

If clinically indicated, once daily starting day after methotrexate dose, and continuing until methotrexate levels less than 0.1 micromol/L (starting on Day 2):

☐ **ALT** ☐ **total bilirubin** ☐ **alkaline phosphatase** ☐ **LDH** ☐ **GGT**

PREMEDICATIONS:

ondansetron 8 mg PO (or ☐ IV) 30 minutes prior to treatment

prochlorperazine 10 mg PO after methotrexate infusion completed

☐ **Other:**

SUPPORTIVE CARE MEDICATIONS:

prochlorperazine 10 mg PO q6h PRN nausea

☐ **Other:**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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DATE:

PRIOR TO METHOTREXATE:

START ALKALINISING REGIMEN 4 TO 12 HOURS PRIOR TO METHOTREXATE

Discontinue all other IV hydration before starting alkalinizing regimen.

Start IV D5W with potassium chloride 20 mEq/L and sodium bicarbonate 150 mEq/L at 125 mL/h for at least 4 hours prior to methotrexate until urine pH is greater than 7. Hydration may be temporarily held during methotrexate infusion (per physician/nursing discretion). Continue hydration post-methotrexate infusion until methotrexate level is less than 0.1 micromol/L.

Check **urine pH** prior to starting methotrexate

If urine pH less than 7, continue alkalinising regimen until pH greater than 7

TREATMENT:

If urine pH greater than or equal to 7, give:

methotrexate 12 grams/m^2 x BSA =_____g **(maximum dose = 20 grams)**

☐ Dose modification: _____% =_____ grams/m^2 x BSA = _____ grams

IV in 1000 mL NS over 4 hours on **Day 1**

Note: See protocol for maximum doses for dose modifications

24 hours after **start** of methotrexate infusion begin:

leucovorin 25 mg IV q6h x 4 doses, then **leucovorin 25 mg** PO q6h until methotrexate level less than 0.1 micromol/L (Starts on **Day 2**)

leucovorin dose may need to be adjusted upwards depending on methotrexate level. See protocol for details.

AFTER METHOTREXATE:

Measure **urine pH** q6h. If pH less than 7, notify MD

At hour 48 from start of methotrexate infusion, or morning of **Day 3** (methotrexate given on Day 1), then once daily every morning: **methotrexate levels** until level less than 0.1 micromol/L; note date and time of withdrawal as well as start time of infusion on specimen. MD to be notified of all results immediately

Continue alkalinising regimen of IV D5W with potassium chloride 20 mEq/L and sodium bicarbonate 150 mEq/L at 125 mL/h post-methotrexate infusion until methotrexate level is less than 0.1 micromol/L.

If urine pH less than 7, continue alkalinising regimen until pH greater than 7

Note: One staff Physician signature is required. Orders written by other providers MUST be co-signed.

DOCTOR 1 SIGNATURE: **DOCTOR 2 SIGNATURE:**

SIGNATURE:

UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **one** week for Doctor and Cycle_____, Week 5 methotrexate. Admit for Day 1 (plan for 4 day admission) ☐ Return in **one** week for Doctor and Cycle _____, Week 1 DOXOrubicin and CISplatin. Admit for Day 1 (plan for 2 day admission) ☐ Return in **two** weeks (post-operatively) for Doctor and Cycle 3 Week 1 DOXOrubicin and CISplatin. Admit for Day 1 (plan for 2 day admission) ☐ Return in **one** week for Doctor and Cycle _____, Week 1 DOXOrubicin. Plan treatment in ambulatory care setting (if applicable) on Days 1 and 2. ☐ Last treatment. Return in _____ week(s).	
CBC & Diff, sodium, potassium, creatinine, calcium, magnesium, albumin, total bilirubin, alkaline phosphatase, ALT, LDH, GGT prior to Day 1 of each treatment ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**