Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Methotrexate for Ectopic Pregnancy

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****
**** Height, weight, and BSA are required for a complete order****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Patients must return for hCG lab test on the 4th and 7th days after the first dose or weekly after the second dose.
3. If patient's experience less than a 15% decline in human chorionic gonadotropin beta-subunit (hCG) titer between days 4 and 7, a second dose should be ordered.
4. If patient's experience greater than a 15% decline in hCG titer between days 4 and 7, a second dose IS NOT needed. Continue to follow weekly levels until hCG is less than 10mIU/mL.
5. Patients are at higher risk of treatment failure if pre-treatment hCG is greater or equal to 5000 mIU/mL. Multiple doses may need to be given. Patients should have WBC, ANC, liver function, and renal function tested prior to and during therapy.
6. Patients should not take NSAIDS, aspirin, or vitamins containing folic acid during therapy. Barrier contraception or oral contraceptives should be used for at least 2 months after completion of therapy. Patients should not drink alcohol until ectopic pregnancy is resolved.
7. Inform patients to notify provider of increase in vaginal bleeding and/or abdominal pain IMMEDIATELY. Other signs and symptoms to report to provider include dizziness, tachycardia, palpitations, and/or syncope.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- HCG Titer Result. _____ mIU/mL, Date: _____

LABS:

- ☐ ABO & Rh Blood Type, Routine, ONCE, every ____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ HCG Beta (plasma), routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ HCG Beta (plasma), routine, ONCE, weekly, until hCG is less than 10 million IU/mL

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CHEMOTHERAPY:

- **Methotrexate 50 mg/m2 = _____ mg, intramuscular, ONCE**
  Final concentration is 25 mg/mL. Total dose may be divided into two syringes by pharmacist during order verification.

OTHER:

Rh negative patients:

☐ Rho(D) Immune Globulin (MICRhoGAM) injection, 50 mcg, intramuscular, ONCE

Rho(D) Immune Globulin will be administered in **(must check one)**

☐ Provider's office
☐ Infusion Center

NURSING ORDERS:

1. Please indicate patient's Rh status and date: Rh positive (date): _____ Rh negative (date): _____
2. TREATMENT PARAMETERS – Hold chemotherapy and notify provider for hCG greater than or equal to 5000 million IU/mL, WBC less than 3000 cells/mm3, ANC less than 1500 cells/ mm3, T-bili greater than 3 mg/dL, SCr greater than 1.2 mg/dL, or calculated CrCl of less than 50 mL/min.
3. Methotrexate to be administered ONLY by chemotherapy certified RN or low dose methotrexate (ectopic pregnancy) chemotherapy competent RN.
4. Confirm patient received education regarding the following:
   a. Return for hCG lab test on the 4th and 7th days after the first dose or weekly after the second dose
   b. DO NOT take any NSAIDS or aspirin. Patient may take acetaminophen.
   c. DO NOT take any vitamin preparations containing folic acid.
   d. DO NOT drink alcohol until ectopic pregnancy is resolved.
   e. Refrain from intercourse until provider indicates it is safe. Use barrier contraception or oral contraceptives for at least 2 months after completion of therapy.
   f. Notify provider of increase in vaginal bleeding and/or abdominal pain IMMEDIATELY. Other signs and symptoms to report to provider include dizziness, tachycardia, palpitations, and/or syncope.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ TUALITY HEALTHCARE
An OHSU Partner

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☐ MCMC
MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

Celilo Cancer Center
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