ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Methotrexate for Ectopic Pregnancy

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis: ❑ Ectopic Pregnancy ❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code, supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Patient height = _____weight = _____ lb/kg BSA = _____ m2

(patient height and weight are required for BSA dosing)

Treatment Regimen:

Methotrexate 50 mg/m2 IM x 1 dose

- Calculated dose rounded to nearest 5 mg = _____ mg
- Note - dose will be divided into 2 injections if dose is greater than 75 mg

☑ **Vital Signs:** Check vital signs prior to and after injection.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)
Special Instructions: Discharge patient 15 minutes after methotrexate injection if stable

Provide printed information on Methotrexate for Ectopic Pregnancy with the following instructions:

- Avoid intercourse until hCG is undetectable
- Avoid pelvic exam until hCG has normalized due to theoretical risk of tubal rupture
- Avoid sun exposure for 1 week to limit risk of methotrexate dermatitis
- Avoid nonsteroidal anti-inflammatory drugs for 72 hours after injection due to potential drug interaction with methotrexate
- Follow-up with provider for questions or concerns

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

METHOTREXATE FOR ECTOPIC PREGNANCY

MultiCare

78-0027-9MR (Rev. 9/24)