The following orders will be enacted unless a specific order is written to the contrary:

1. LABS: Draw labs upon patient’s arrival, prior to Methotrexate administration.
   ➞ For ITC: send all lab values to OB/GYN provider prior to administering Methotrexate. Any abnormal values should be called to the provider’s office.

   ✓ hCG, quantitative – highest success with hCG ≤ 5000 mIU/ml
     (failure rate of ≥ 14.3% when hCG > 5,000 mIU/ml, compared to 3.7% failure rate < 5000 mIU/ml)
   ✓ CBC with diff
   ✓ CMP
   ✓ ABO and Rh Type

2. Contraindications: (Provider has screened for the following)
   **Absolute:**
   - Immunodeficiency
   - Liver disease with transaminases (ALT, AST) more than double normal
   - Current alcoholism
   - Elevated serum creatinine
   - Significant pulmonary disease
   - Hematologic abnormalities (e.g. significant anemia, thrombocytopenia, or leukopenia)
   - Peptic ulcer disease
   - Breastfeeding
   - Patients unable or unwilling to comply with post-treatment monitoring and follow-up

   **Relative Contraindications:**
   - Gestational sac larger than 3.5 cm
   - Embryonic cardiac motion

   ➞ Nursing to verify in MAK that BSA is correct, and calculate dose prior to administration. Second RN to complete independent double-check.

3. Dosage:
   Note: Methotrexate must be prepared in chemotherapy hood (Seacoast Cancer Center).
   Following administration, dispose of used equipment in yellow chemotherapy container.

   ✓ Methotrexate 50 mg/m² (50 x BSA) Intramuscular x 1 dose. Preferred site ventrogluteal muscle.

   Patient height (measured): ____ (inches)   Weight (measured): ____ (kg)
   Body Surface Area (BSA): ___________m² (BSA is calculated using the Mosteller formula)

   • **Dose:** 50 mg x _____ (BSA) = _____ mg. Doses greater than 2 ml in volume should be divided into 2 syringes.

4. Notify Physician if any suspected drug reaction

5. Patient Instructions: Follow up with Gynecologist on ___________ (Date)

6. Consulted with OB/GYN: ____________________________________________ (Print name here)

   _______________________________  _______________________________
   Physician Signature            Date / Time

Wentworth–Douglass Hospital
PHYSICIAN ORDERS

Methotrexate for Ectopic Pregnancy

6231−240MR
PO0020
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