P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

FOLOTYN® (Pralatrexate injection)

Patient's Surname	**Given Name & Initials**	**Date of birth** ______ / ______ / ________ dd mm yyyy
Referring MD/Oncologist		

Patient's Height: __________ cm Weight: __________ kg BSA: ____________ m^2	Dose Reduction? Yes ☐ No ☐ Reason____ Cycle: ____

Pre-Medication

Daily Folic Acid 1 mg PO daily should be initiated 10 days before first dose of pralatrexate.

Vitamin B_{12} 1 mg IM injection should be initiated at least 1 week before the first dose and then every 8 to 10 weeks

☐ **Folotyn® (Pralatrexate) ……..mg (30 mg/m^2) IV push injection over 3 – 5 minutes**

or ☐ **Folotyn® (Pralatrexate) ……..mg (………mg/m^2) IV push injection over 3 – 5 minutes**

Scheduled Frequency **Folotyn is given 3 weeks out of 4 weeks (4th week off)**
(CBC will be required before each cycle.)

(For Provis Use Only)

Tx ____: ___________________________(date of Tx) Tx ____: ___________________________(date of Tx)

Tx ____: ___________________________(date of Tx)

Physician's Signature (Referring Oncologist)	______ / ______ / ________ dd mm yyyy
Signature of Provis Physician	______ / ______ / ________ dd mm yyyy

Repeat Order:

Provis requires a new medication order for each cycle

Fax completed form to: 416-532-3635