a trchealthcare brand
Pharmacist's Letter
Hospital

Prevent Mishaps Involving Unusual Dosing Schedules

Top Takeaways

- *During med histories and order verification, watch for meds that usually have out of the ordinary dosing, and make sure that the dosage form, strength, and directions all align.*
- *Confirm timing of the last outpatient dose to help prevent duplicate or early dosing during admission.*
- *Use system safeguards and clear directions, such as hard stops or naming the specific day for weekly meds, to reduce error risk.*

You'll see more focus on **med errors related to unique dosing schedules (weekly, monthly, etc) in the hospital**.

For example, FDA recently added a boxed warning for methotrexate about fatal med errors where weekly doses were accidentally taken daily.

Watch for meds that usually have out of the ordinary dosing during med histories and order verification...and make sure that the dosage form, strength, and directions all line up.

For instance, scopolamine patches are usually dosed every 3 days...clonidine patches are weekly...and paliperidone IM injections can be every 1, 3, or 6 months, depending on the dose or brand.

Similarly, stay alert for meds with alternating doses. For example, warfarin may be given in one strength for 3 days a week...and a different strength for the other 4 days. And we know the regimen can change often.

Verify that the frequency matches the indication. For example, po methotrexate is usually dosed WEEKLY for autoimmune disorders (psoriasis, etc)...but doses for some cancers can be daily, 2 to 4 times weekly, etc.

Note meds with different frequencies depending on the dosage form. For instance, buprenorphine sublingual tabs are dosed DAILY...the patch is WEEKLY...and certain subcut injection brands are weekly OR monthly.

Look for unusual doses due to lab abnormalities. For instance, levofloxacin may be adjusted from daily to Q48H based on kidney function.

Work with IT to implement "high dose" flags or hard stops for meds with weekly or monthly dosing that may accidentally get entered as daily.

Likewise, IT can help configure e-Rx settings so that only clinically appropriate frequency options appear for certain meds.

Stay alert for mix-ups during admission or discharge.

Verify timing of the last dose a patient took at home if they're on a weekly or monthly med...so they don't get redosed too soon.

Check your hospital's policy if a patient comes in with a long-acting patch on board. Some hospitals require removal and replacement of patches upon admission as an added safety measure.

If a patient gets discharged on a weekly med, advise using the specific day in the directions, such as "every Friday" instead of "weekly" to help them remember.

See our *Responding to Med Errors* checklist for more guidance to help ensure patient safety and reduce error risk.

Key References:

Cite this document as follows: Article, Prevent Mishaps Involving Unusual Dosing Schedules<br class="t-last-br" />, Hospital Pharmacist's Letter, September 2026

-ISMP. Acute Care Safety Alert! Longstanding Strategies to Prevent Accidental Daily Methotrexate Dosing Must Be Implemented. August 9, 2018. https://home.ecri.org/pages/ismp/ (Accessed August 18, 2026).
-FDA. Drug Safety-Related Labeling Changes. Methotrexate sodium. May 27, 2026. https://www.accessdata.fda.gov/scripts/cder/safetylabelingchanges/index.cfm?event=searchdetail.page&DrugNameID=1479 (Accessed August 18, 2026).
-NABP. ISMP Safety Brief: Prevent Additional Patient Harm and Deaths From Accidental Daily Methotrexate Dosing. March 22, 2024. https://nabp.pharmacy/news/blog/regulatory_news/ismp-safety-brief-prevent-harm-from-methotrexate/ (Accessed August 18, 2026).

Hospital Pharmacist's Letter. September 2026, No. 420933