ADULT AMBULATORY INFUSION ORDER

Denosumab (PROLIA)
Osteoporosis

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**

REstrictions: Please select P & T approved criteria for use

☐ Osteoporosis in men or postmenopausal women
☐ Bone loss in men receiving androgen deprivation therapy for prostate cancer
☐ Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer

GUIDELINES FOR ORDERING
1. Send FACE SHEET and H&P or most recent chart note.
2. Please confirm that patient has had recent oral/dental evaluation if indicated prior to initiating therapy.
3. All patients should be prescribed daily calcium and Vitamin D supplementation.
4. Recommended quarterly monitoring of serum magnesium, calcium, and phosphate levels should be obtained during therapy.
5. Risk verses benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
6. A complete metabolic panel is recommended and a calcium level must be obtained within 90 days prior to starting treatment.

LABS:
☐ CMP, Routine, ONCE, every 6 months as needed

MEDICATIONS:
- denosumab (PROLIA) injection, 60 mg, subcutaneous, ONCE, every 6 months for 2 treatments
  Administer injection into upper arm, upper thigh, or abdomen

NURSING ORDERS:
1. Review previous serum Calcium.
2. TREATMENT PARAMETER – Calcium must be corrected prior to administration. Hold and notify MD for corrected calcium less than 8.4 (use calcium and albumin from previous treatment for calculation).
3. Assess for jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.

PROVIDER TO PHARMACIST COMMUNICATION:
1. If corrected calcium is between 8.4 and 8.8, pharmacist will review home medication list for calcium and vitamin D supplementation. If patient is not on these agents, provider will be notified.
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: ___________________________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

□ Beaverton
   OHSU Knight Cancer Institute
   15700 SW Greystone Court
   Beaverton, OR 97006
   Phone number: 971-262-9000
   Fax number: 503-346-8058

□ NW Portland
   Legacy Good Samaritan campus
   Medical Office Building 3, Suite 150
   1130 NW 22nd Ave.
   Portland, OR 97210
   Phone number: 971-262-9600
   Fax number: 503-346-8058

□ Gresham
   Legacy Mount Hood campus
   Medical Office Building 3, Suite 140
   24988 SE Stark
   Gresham, OR 97030
   Phone number: 971-262-9500
   Fax number: 503-346-8058

□ Tualatin
   Legacy Meridian Park campus
   Medical Office Building 2, Suite 140
   19260 SW 65th Ave.
   Tualatin, OR 97062
   Phone number: 971-262-9700
   Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders