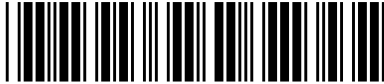
Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071 

ADULT AMBULATORY INFUSION ORDER

Denosumab (PROLIA) Osteoporosis

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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