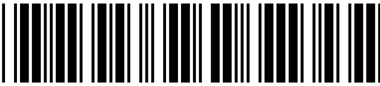
Oregon Health & Science University
Hospital and Clinics Provider's Orders



PO7071

ADULT AMBULATORY INFUSION ORDER

Pamidronate (AREDIA)

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****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Maximum dose should be 90 mg. Infusion rates vary by indication and renal function. Longer infusion times may reduce the risk for renal toxicity, especially in patients with preexisting renal insufficiency.
3. Please confirm that patient has had recent dental evaluation prior to initiating therapy.
4. In the absence of hypercalcemia, all patients with the following diagnoses should be prescribed daily calcium and vitamin D supplementation:
   - Lytic bone metastases
   - Multiple Myeloma
   - Paget's disease

LABS:

- ☐ CMP, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Magnesium (plasma), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Phosphorus (plasma), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CBC with differential, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Bone Specific Alk Phos (serum), Routine, ONCE, every ____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: ________

NURSING ORDERS:

1. Review previous serum creatinine (SCr) and previous serum Calcium, Magnesium, Phosphorus and Albumin. If no results in past 90 days, order CMP, Magnesium, Phosphorus, and Albumin.
2. TREATMENT PARAMETERS – Hold and notify MD for serum creatinine greater than 3 mg/dL or creatinine clearance ≤ 30 mL/min
3. TREATMENT PARAMETERS – 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).
4. Assess for jaw pain. Inform provider if positive findings or if patient is anticipating dental work.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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 (exception: Hypercalcemia).
2. Pharmacist to adjust infusion rate for renal insufficiency. Doses will be infused over 4-6 hours for a SCr ≥ 3 mg/dL or CrCl ≤ 30 mL/minute

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MEDICATIONS:

1. **Paget's disease**
   ☐ pamidronate (AREDIA) 30 mg in NaCl 0.9% 500 mL, intravenous, ONCE, over 4 hours

   Interval:
   - Daily x 3 consecutive days for a total of 90 mg

2. **Hypercalcemia of malignancy**
   ☐ pamidronate (AREDIA) _____ mg in NaCl 0.9% 1000 mL, intravenous, ONCE, over 2 hours

   Interval: ***(must check one)***
   ☐ Once
   ☐ Repeat every _______ weeks, at least 7 days apart

3. **Osteolytic bone metastases of breast cancer**
   ☐ pamidronate (AREDIA) _____ mg in NaCl 0.9% 250 mL, intravenous, ONCE, over 2 hours

   Interval: ***(must check one)***
   ☐ Once
   ☐ Repeat every _______ weeks, at least 3 weeks apart. Usual intervals are 4, 8, or 12 weeks

4. **Osteolytic bone lesions of multiple myeloma**
   ☐ pamidronate (AREDIA) _____ mg in NaCl 0.9% 500 mL, intravenous, ONCE, over 2 hours

   Interval: ***(must check one)***
   ☐ Once
   ☐ Repeat every _______ weeks, at least 3 weeks apart. Usual intervals are 4, 8, or 12 weeks

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 # __________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; 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:**______________

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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