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. 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. In patients with severe renal impairment (creatinine clearance less than 30 mL/min), high risk of hypocalcemia, disturbances of mineral metabolism (e.g. hypoparathyroidism, thyroid surgery, parathyroid surgery, malabsorption syndromes, excision of small intestines) recommend clinical monitoring of calcium, magnesium and phosphorus levels within 14 days of Prolia injection.
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 60 days prior to starting treatment
7. Pregnancy must be ruled out prior to administration. Perform pregnancy testing in all females of reproductive potential prior to administration of Prolia.

**LABS:**

- Complete metabolic panel, routine, ONCE, every visit

**NURSING ORDERS:**

1. Review previous creatinine clearance, serum calcium and albumin. If no results in past 60 days order CMP.
2. TREATMENT PARAMETER – Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 mg/dL.
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
4. Remind patient to take at least 500 mg elemental calcium twice daily and 400 units vitamin D daily.

**MEDICATIONS:**

denosumab (PROLIA) injection, 60 mg, subcutaneous, every 6 months (26 weeks) x 2 doses,
Administer injection into upper arm, upper thigh, or abdomen
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