
 <div style="text-align: center;"> <b>Oregon Health &amp; Science University Hospital and Clinics Provider's Orders</b> </div> <div style="text-align: center; margin-top: 10px;">  </div> <div style="text-align: center; margin-top: 10px;"> <small>ADULT AMBULATORY INFUSION ORDER</small>  <b>Denosumab (PROLIA) Injection</b>  <b>Osteoporosis</b> </div> <div style="text-align: center; margin-top: 10px;"> <small>Page 1 of 2</small> </div>	<div style="margin-top: 20px;"> ACCOUNT NO.  MED. REC. NO.  NAME  BIRTHDATE </div> <div style="text-align: right; margin-top: 20px;"> <i>Patient Identification</i> </div>
<b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.</b>	

**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. All patients should be prescribed daily calcium and vitamin D supplementation
3. 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.
4. Risk verses benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
5. A complete metabolic panel is recommended and a calcium level must be obtained within 60 days prior to starting treatment
6. The corrected calcium level should be greater than or equal to 8.4 mg/dL.
7. Pregnancy must be ruled out prior to administration. Perform pregnancy testing in all females of reproductive potential prior to administration of Prolia.
8. **Must complete and check the following box:**
  - ☐ Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

#### **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



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

ADULT AMBULATORY INFUSION ORDER  
**Denosumab (PROLIA) Injection**  
**Osteoporosis**

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ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

*Patient Identification*

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**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:** \_\_\_\_\_

Central Intake:

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](http://www.ohsuknight.com/infusionorders)