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 versus 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. Do not hold treatment for CrCl less than 30 mL/min.
5. 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: __________

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