# Pamidronate (AREDIA) Infusion



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. 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
3. **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:

- ☐ 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*
- ☐ Bone Specific Alk Phos (serum), Routine, ONCE, every ____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

## NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. TREATMENT PARAMETERS
   a. Pharmacist to calculate Corrected Calcium. Hold and notify provider for Corrected Calcium less than 8.4 mg/dL.
   b. Hold and notify provider for serum creatinine 3 mg/dL greater, or estimated creatinine clearance 30 mL/min or less if patient does not have multiple myeloma.
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.

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**MEDICATIONS:**

**1. Paget's disease**

☐ pamidronate (AREDIA) 30 mg in sodium chloride 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 sodium chloride 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 sodium chloride 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 sodium chloride 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

**PROVIDER TO PHARMACIST COMMUNICATION – For multiple myeloma only** – Pharmacist to adjust infusion rate for renal insufficiency. Doses will be infused over 4-6 hours for serum creatinine 3 mg/dL or greater, or estimated creatinine clearance 30 mL/min or less

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**HYPERSENSITIVITY MEDICATIONS:**

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

**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**: _____

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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