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
2. **Must complete and answer the following question:**
   Osteonecrosis of the jaw (ONJ) has been reported in patients receiving this medication. Risk factors include higher doses, duration of therapy greater than 2 years, cancer diagnosis, concurrent immunosuppression, poor oral hygiene, periodontal disease, ill-fitting dentures, and invasive dental procedures (among others). Provider attests that patient has had a dental evaluation or has no contraindications to therapy related to dental issues prior to initiating therapy.
   Osteonecrosis of the jaw (ONJ) risk reviewed prior to initiation of therapy? ____ (Yes/No)

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. TREATMENT PARAMETER #1 – When labs are ordered:
    a. If serum calcium is greater than or equal to 8.4 mg/dL: OK to proceed with treatment.
    b. If serum calcium less than 8.4 mg/dL AND albumin is less than 4.35 mg/dL: Calculate corrected calcium: Hold treatment and notify provider if corrected calcium is less than 8.4 mg/dL.
    c. If serum calcium less than 8.4 mg/dL AND albumin is greater than or equal to 4.35 mg/dL: Hold treatment and notify provider.
2. TREATMENT PARAMETER #2 - Assess for new or unusual thigh, hip, groin, or jaw pain. Hold treatment and Contact provider if positive findings.
   Invasive dental work includes dentoalveolar procedures such as tooth extraction, root canal, or placement of dental implants. Hold treatment and notify provider if the following has not been discussed with the ordering provider:
    a. If patient is anticipating invasive dental work in the next 3 months
    b. Has received invasive dental work in the last 8 weeks

c. Has a new diagnosis of severe periodontal disease

3. TREATMENT PARAMETER #3 - Hold treatment and notify provider for Serum Creatinine 3 mg/dL or greater, or estimated Creatinine Clearance 30 mL/min or less if patient does not have multiple myeloma.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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, 0.5 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