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

PO9031

ADULT AMBULATORY INFUSION ORDER

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 NaCl 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 NaCl 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 NaCl 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 NaCl 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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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:**_____________

Please check the appropriate box for the patient's preferred clinic location:

☐

Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

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Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610