Denosumab (PROLIA) Injection Osteoporosis

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. 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 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:

☐ Complete metabolic panel, routine, ONCE, every visit

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.

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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. Review previous creatinine clearance, serum calcium and albumin. If no results in past 60 days, order CMP.
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

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

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

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

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756