

Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER Pamidronate (AREDIA) Infusion Page 1 of 3	ACCOUNT NO. _____ MED. REC. NO. _____ NAME _____ BIRTHDATE _____ <i>Patient Identification</i>
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. **Provider must review and check box for 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?

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:



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

ADULT AMBULATORY INFUSION ORDER
Pamidronate (AREDIA) Infusion

Page 2 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

- 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, dec clotting (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



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

ADULT AMBULATORY INFUSION ORDER
Pamidronate (AREDIA) Infusion

Page 3 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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:** _____

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

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

☐ **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