Outpatient Prolia (denosumab) Order Set

Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name ___________________ DOB ___________ Height _____ Weight ______ Phone #___________

Order Start Date __________________________ Order Expiration Date *(max one year)* _____________________

Allergies: ____

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 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.

DIAGNOSIS CODE:

☐ M81.0 Postmenopausal Osteoporosis

☐ Other: _________________________

Nursing Orders

☒ If no results in the past 60 days, order CMP.

☒ Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.

☒ Remind patient to take at least 500 mg elemental calcium twice daily and 400 units vitamin D daily.

☒ Vital Signs: baseline and at discharge. Hold patient for 15 minutes post-administration to observe/monitor for adverse reaction

Medication Orders

☒ Prolia (denosumab) 60mg/1mL by subcutaneous route every 6 months for _____ total doses. Administer injection into upper arm, upper thigh, or abdomen.

IF HYPERSENSITIVITY OR ANAPHYLACTIC REACTION OCCURS

☒ Notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in ____________ *(specify state)*

My physician license number is # _________________ 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** ______________

Printed name: ______________________ **Phone:** _____________ **Fax:** _____________

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: ________________________________ **Date** ______________

Printed name: ______________________

Patient Name:

DOB: