| | | |
|---|---|---|
| LEGACY HEALTH | **Legacy Day Treatment Unit Provider's Orders**<br><br>Adult Ambulatory Infusion Order<br>DENOSUMAB (PROLIA)<br>OSTEOPOROSIS | **Patient Name:**<br>**Date of Birth:**<br>**Med. Rec. No** (TVC MRN Only): |
| ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE | | |

**Anticipated Start Date:** _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****

**Orders expire:** _____

**Weight:** _____kg **Height:** _____cm

**Allergies:** _____

**Diagnosis:** _____ **Diagnosis Code:** _____

**GUIDELINES FOR PRESCRIBING:**

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
3. Hypocalcemia must be corrected before initiation of therapy. The corrected calcium level should be greater than or equal to 8.4 mg/dL.
4. All patients should be prescribed daily calcium and vitamin D supplementation.
    a. Recommended dosing: calcium 1000 mg and vitamin D 400 IU daily
5. A complete metabolic panel must be drawn within 60 days prior to starting treatment.
6. 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.
7. Pregnancy must be ruled out prior to administration. Perform pregnancy testing in all females of reproductive potential prior to administration of Prolia. It is the responsibility of the ordering provider to determine necessity and obtain results, if indicated. This is not a hold parameter for infusion staff.
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.

**LABS TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):**

☐ CMP, Routine, every 6 months prior to Prolia dose

**MEDICATIONS:**

- denosumab (PROLIA) 60 mg (1 mL) SUBCUTANEOUSLY, every 6 months (26 weeks) for 2 treatments
  Administer injection into upper arm, upper thigh, or abdomen

| | | |
|---|---|---|
| LEGACY HEALTH | **Legacy Day Treatment Unit Provider's Orders**<br><br>Adult Ambulatory Infusion Order<br>DENOSUMAB (PROLIA)<br>OSTEOPOROSIS | **Patient Name:**<br>**Date of Birth:**<br>**Med. Rec. No** (TVC MRN Only): |
| ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE | | |

**NURSING ORDERS (TREATMENT PARAMETERS):**

1. Review previous creatinine clearance, serum calcium and albumin. If no results in past 60 days order CMP.
2. Treatment parameters, ONCE: Hold and notify MD for corrected calcium LESS than 8.4 mg/dL.
3. If corrected calcium is between 8.4 and 8.8 or creatinine clearance LESS than 30 mL/min review home medication for calcium and vitamin D supplementation. If patient is not on these agents, notify provider.
4. Do not hold treatment for CrCl <30 mL/min
5. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
6. Remind patient to take calcium and vitamin D supplements, as directed by prescribing provider.

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

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
*A department of Salmon Creek Medical Center*
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Emanuel Day Treatment Unit**
*A department of Emanuel Medical Center*
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy STEPS Clinic**
*A department of Silverton Medical Center*
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

**Provider signature:** _____ **Date/Time:** _____

**Printed Name:** _____ **Phone:** _____ **Fax**: _____

**Organization/Department:** _____

| | | |
|---|---|---|
| LEGACY HEALTH | **Legacy Day Treatment Unit Provider's Orders**<br><br>Adult Ambulatory Infusion Order<br>DENOSUMAB (PROLIA)<br>OSTEOPOROSIS | **Patient Name:**<br>**Date of Birth:**<br>**Med. Rec. No** (TVC MRN Only): |
| ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE | | |

# Dental Clearance Letter

Re: _____ DOB:_____

To Whom It May Concern:

Our mutual patient noted above is scheduled to start denosumab or a bisphosphonate medication for the medical treatment of _____.

It has been reported that a small number of patients taking these medications may develop a condition known as osteonecrosis following certain dental treatments. We are requesting a dental clearance prior to the initiation of the medical treatment. Please perform a complete dental evaluation and treat any dental conditions that may lead to future teeth extractions or other invasive dental procedures.

Thank you for your assistance.

_____
Name of referring medical practitioner

Date of last dental exam: _____

☐ Patient is free of active dental infection or need for further dental treatments and is cleared to receive denosumab or a bisphosphonate medication

☐ Patient is NOT cleared to receive denosumab or a bisphosphonate medication

Additional comments:

_____
_____
_____

| _____ | _____ | _____ |
|---|---|---|
| Printed name of Dentist | Signature of Dentist | Date |

Please fill out and fax this letter to the infusion center where patient will receive treatment. Attn: Pharmacist

Fax:_____