LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order DENOSUMAB (OSENVELT / XGEVA)	**Patient Name:** **Date of Birth:** **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. Please confirm that patient has had a recent oral examination prior to initiating therapy. Schedule for a dental exam if indicated – dental clearance form on page 3, if needed
3. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment
4. Hypocalcemia must be corrected before initiation of therapy
5. All patients should be prescribed daily calcium and vitamin D supplementation
    a. Recommended dosing: calcium 1200 mg and vitamin D 400 IU-800 IU daily
6. Quarterly monitoring of calcium, magnesium, and phosphorous is recommended during treatment
7. CMP must be within 7 days of treatment for every 4 weeks dosing or within 30 days of treatment for every 12 weeks dosing, unless otherwise specified: _____

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

☐ CMP, Routine, every visit prior to Xgeva dose

DENTAL CLEARANCE: (Must select one)

☐ Dental clearance required prior to initiation (form on page 3) – **Recommended, not required**
☐ Patient may be treated without documentation of dental clearance

MEDICATIONS:

- Denosumab-bmwo (OSENVELT) 120 mg (1.7 mL) SUBCUTANEOUSLY, every visit. Administer injection into upper arm, upper thigh, or abdomen

☐ Check this box only if the reference product (XGEVA) must be used.

FREQUENCY:

☐ Every 4 weeks
☐ Every 12 weeks
☐ Other _____

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NURSING ORDERS (TREATMENT PARAMETERS):

1. Nursing order, ONCE: Review previous serum creatinine (SCr) and serum calcium
2. Treatment parameters, ONCE: Hold and notify MD for corrected calcium less than 8.4.
3. Nursing communication order, every visit: If corrected calcium is between 8.4 and 8.8 or creatinine clearance <30 mL/min review home medication for calcium and vitamin D supplementation. If patient is not on these agents, notify provider
4. Assess for jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work
5. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

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 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 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 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: _____

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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:_____