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 (Xgeva) 120 mg (1.7 mL) SUBCUTANEOUSLY, every visit. Administer injection into upper arm, upper thigh, or abdomen

FREQUENCY:

☐ Every 4 weeks
☐ Every 12 weeks
☐ Other _____________
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

HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients
1. diphenhydramine 25-50 mg IV AS NEEDED x1 for hypersensitivity reaction (Max dose: 50 mg)
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction

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

☐ Legacy Day Treatment Unit
  700 NE 87th Avenue, Suite 360
  Vancouver, WA 98664
  Phone number: 360-896-7070
  Fax number: 360-487-5773

☐ Legacy Silverton STEPS Clinic
  Legacy Silverton Medical Center
  342 Fairview Street
  Silverton, OR 97381
  Phone number: 503-873-1670
  Fax number: 503-874-2483

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

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

Provider signature: ____________________________ Date/Time: ____________________________
Printed Name: ____________________________ Phone: __________________ Fax: _______________
Organization/Department: ____________________________________________

Last updated 04/27/2020
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

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

Fax: ______________________________

Last updated 04/27/2020