LEGACY HEALTH	Legacy Day Treatment Unit Provider's Orders Adult Ambulatory Infusion Order DENOSUMAB (PROLIA) OSTEOPOROSIS	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 ex	xpire:				
Weight: _ Allergies	kg <b>Height:</b> :	cm			

### **GUIDELINES FOR PRESCRIBING:**

Diagnosis: \_\_\_\_\_

- 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

Diagnosis Code: \_\_\_\_\_

- 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
- All patients should be prescribed daily calcium and vitamin D supplementation

   Recommended dosing: calcium 1200 mg and vitamin D 400 IU-800 IU daily
- 6. CMP must be drawn within 90 days prior to starting treatment
- 7. Quarterly monitoring of calcium, magnesium, and phosphorous is recommended during treatment
- 8. For patients predisposed to hypocalcemia and disturbances of mineral metabolism (history of hyperparathyroidism, thyroid surgery, parathyroid surgery, malabsorption syndromes, excision of small intestine, CrCI LESS than 30 mL/min, treatment with other calcium-lowering drugs, or baseline calcium LESS than or EQUAL to 8.8:
  - a. Consider monitoring calcium, magnesium, and phosphorous within 14 days of Prolia injection

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

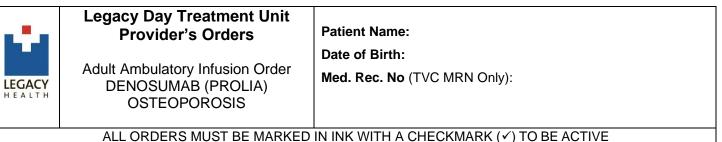
CMP, Routine, every 6 months prior to Prolia dose

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



ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (\*) TO BE

### 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
- Nursing communication order, every visit: 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. 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 87<sup>th</sup> 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 139<sup>th</sup> Street, Suite 110 Vancouver, WA 98686 Phone number: 360-487-1750 Fax number: 360-487-5773

## Legacy Woodburn 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

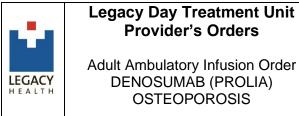
### □ Legacy Emanuel Day Treatment Unit

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 Silverton STEPS Clinic

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

Provider signature:	Date/Time:		
Printed Name:	Phone:	Fax:	
Organization/Department:			



DENOSUMAB (PROLIA)

OSTEOPOROSIS

Patient Name: Date of Birth:

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: