Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Prolia (denosumab) Non-Oncology Treatment Order Set

1. Patient Name: ____

2. DOB: ______________________________________ **Height (inches):** ___________ **Weight (lbs):** ___________

3. Diagnosis:

[ ] M81.0 Age-related osteoporosis without current fracture
[ ] Other ICD-10 Code: ____________________ Diagnosis description: ______________________________

4. Pre-medications:

[ ] Other Pre-medication: ____
[ ] No Pre-medications indicated

5. Drug Order:

Prolia (denosumab)

Dose/ Frequency:

[ ] **60mg subcutaneously every 6 months** (SQ injections to upper arm, upper thigh or abdomen)
[ ] Other: ____

Dental Clearance:

[ ] Ok to proceed without dental clearance
[ ] Ok to proceed, dental clearance obtained, Date: _________ (copy of clearance attached)

[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____________________ Next Dose Due ____________________

- Is the patient on Calcium & Vitamin D replacement? [ ] Yes [ ] No

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] CMP within 30 days of injection
[ ] Other: ____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing have been completed**:

[ ] CMP, date: ________ [ ] DEXA Scan, date: _______ [ ] Other: __________________ [ ] None

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _________________________ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: ____ **Phone:** ___________________
Physician's Signature: ____**Date:** ________________

(This drug administration order form is valid for 12 months)

Dental Clearance for Drug Administration

Patient Name: ____ DOB: _______________________
Prescribing MD: ___________________________________ Prescribing MD Phone Number: _______________

The above mentioned patient requires therapy with the following medication, under my supervision:

_____Zometa

_____Xgeva

_____Aredia

_____Reclast

_____Prolia

_____ Boniva

_____ Evenity

Please evaluate the patient for clearance or any other recommendations following your exam.
The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at (fax) _____________________.

[_] Dental Clearance APPROVED

[_] Dental Clearance DENIED.

See Comments and Recommendation Below:

____

____

____

____

Treating Dentist:_____________________________________

Dentist Signature:____________________________________

Date:____