(denosumab)

PROLIA Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____Age-related osteoporosis ***without*** current pathological fracture
☐ _____Age-related osteoporosis ***with*** current pathological fracture
☐ _____Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HAT)
☐ _____(other)

LABORATORY:

Attach current Calcium lab results (within 60 days prior)
NOTE: Hypocalcemia must be corrected prior to Prolia

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐_____(other)

PROLIA ORDERS:

DOSAGE

⬭ **60mg SQ every six months**

_____**Last Prolia injection date (if applicable)**

PATIENT WEIGHT

_____**LBS**
_____**KG**

⬭ ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered

ORDERING PROVIDER:

Signature _____ **Printed Name:** _____**Date**_____

Practice _____**Phone**_____ **Fax** _____

PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058

REV: 3/2023