LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

DENOSUMAB (*PROLIA*) ADMINISTRATION

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

GENERAL

Last dose administered: _____

GUIDELINES FOR ORDERING

- ***Treatment will be withheld*** *if serum calcium within 30 days is* ***less than*** *8.5, pending repletion*
- *Send* ***History & Physical*** *or most recent chart note*
- *Recent oral and/or dental exam, if indicated AND no invasive dental procedures are planned.* ***Risk vs. benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.***
- *Attach* ***CMP*** *results* ***obtained within last 30 days***
- *Patient should be prescribed daily Calcium and Vitamin D supplementation, unless contraindicated (at least* ***Calcium*** *1000 mg/day and* ***Vitamin D greater than/equal to*** *400 units/day)*
- *Patient with creatinine clearance* ***less than*** *30 mL/minute are at high risk of hypocalcemia*
- ***Recommended the provider to monitor calcium, magnesium and phosphorus levels within 14 days of PROLIA injection.***

NURSING/ ACTIVITIES

Assessments

☒ Review Dietary Intake/Oral Supplementation of Calcium and Vitamin D

Hold and Notify

☒ HOLD and Notify provider if:

- Serum calcium is **less than** 8.5
- New or unusual thigh, hip, groin, or jaw pain
- Patient anticipates invasive dental work or has completed within the last 2 months
- No CMP within 30 days of treatment. Call provider to obtain order for CMP.

Continued next page ➔

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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DENOSUMAB (*PROLIA*) ADMINISTRATION

Patient Name _____ **DOB** _____

MEDICATION

☒ **denosumab** *(PROLIA)* 60 mg/mL subcutaneous **Q 6 months** - Administer into upper arm, upper thigh, or abdomen.

LABS

☐ CMP once Q6 months within 30 days prior to treatment
☐ Obtain CMP if NOT done within 30 days prior to administration of *PROLIA*

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
☒ VS Q15 minutes **x** 4 and PRN
☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose.
May repeat **x** 1 ***{Maximum dose = 50 mg}***
☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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