**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 & BIOSIMILARS

**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 & BIOSIMILARS

**Patient Name** _____ **DOB** _____

**MEDICATIONS:**

☒ BIOSIMILAR **denosumab-nxxp** *(BILDYOS)* is the preferred formulary agent. Other biosimilars may be used based on insurance coverage. For the reference product denosumab *(PROLIA)*, indicate reason for not selecting a biosimilar.

☒ **Select ONE Product:**

☐ **PREFERRED: denosumab-nxxp** *(BILDYOS)* 60 mg/mL subcutaneous **Q 6 months** - Administer into upper arm, upper thigh, or abdomen.

☐ Alternative: **denosumab-bmwo** *(STOBOCLO)* 60 mg/mL subcutaneous **Q 6 months** - Administer into upper arm, upper thigh, or abdomen.

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

**NOTE** reason for not selecting a biosimilar **(required):** _____

**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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