

An Outpatient Department of St. Mary's Hospital
2421 Malcom Bridge Rd Ste 820 Bogart, GA 30622-2325
Phone: 706-389-7802
Fax: 706-389-2501

Denosumab (PROLIA®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____	
Diagnosis Diagnosis Code (ICD-10): ☐ M81.0 ☐ Other _____ Indication: _____ Target start date: _____		Labs Calcium/albumin required within 30 days of treatment ☐ Calcium ☐ Albumin ☐ Other: _____	
NOTE TO PROVIDER: All patients with Denosumab (PROLIA®) prescribed should receive at least 1000 mg Calcium and 400 IU Vitamin D daily per prescribing information (note: Calcium is best absorbed if doses greater than 500 mg are divided).			
Hold and notify provider: Notify provider and hold at provider discretion for Ca <7 mg/dL. Calcium level should be corrected prior to initiation of treatment.			
Denosumab (Prolia) 60 mg subcutaneous injection every 6 months DO NOT SUBSTITUTE- use PROLIA® brand only			
Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____		Hydration ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____ mL/hr ☐ Before ☐ During ☐ Following

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Flushing Protocol <i>as needed for line care</i>	☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL	Heparin 100 Units/mL ☐ 5 mL ☐ 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure	
Provider Name: _____ Provider Signature: _____ Attending Physician Name: _____ Provider NPI: _____ Office Phone Number: _____ Office Fax Number: _____ <i>Note: This order is valid for 12 months from date of physician signature.</i>		