Ascension St. Vincent's

Outpatient infusion center
Phone 904-296-5994 Fax 904-296-9070

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____
Insurance: _____
Subscriber ID: _____
Infusion Site: _____

Denosumab (Prolia, Jubbonti, Stoboclo, Bildyos, Conexxence, Enoby, etc) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List:_____

Diagnosis	ICD 10 Code(s)	CPT Code
☐ Osteoporosis ☐ Other:_____	☐ M80.0_ _ _ ☐ Other:_____	☑ CPT Code: _____

Labs (prior to scheduling infusion)	Provider Information
☑ Calcium Level ☑ 25-hydroxyvitamin D level ☑ BMP ☐ Other: _____	- REMS requirement - Provide and review patient guide with each patient. -Verify patient compliance/dosage of oral calcium/vitamin D supplementation. Assess for calcium abnormalities and need to modify oral calcium/vitamin D supplementation. -Confirm with the patient that a dentist/prescriber has visually inspected the oral cavity prior to initiation of therapy and is receiving ongoing evaluation for signs of osteonecrosis. Assess for jaw pain or upcoming invasive dental work.

Nursing Orders	Premedications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once ☐ Cetirizine 10 mg PO, once ☐ Dexamethasone 20 mg IV, once ☐ Ondansetron 4 mg IV, once ☐ Diphenhydramine 25 mg PO, once	☐ Diphenhydramine 25 mg IV, once ☐ Other:_____ ☐ Other:_____
Emergency/Anaphylaxis Order		
☑ Follow standard orders for management of allergies and anaphylaxis reactions		

Medication Orders

	Medication*/J-Code	Route	Dose	Frequency	Select Treatment Type
☐ ☐ ☐ ☐ ☐ ☐ ☐	Prolia/J0897 Jubbonti/Q5136 Stoboclo/Q5157 Bildyos/J3590 Conexxence/Q5158 Enoby/J3590 Other: _____ / Jcode: _____	SQ	60 mg	Once	☐ Maintenance: Every 6 months for____ dose(s) ☐ Other:_____

Order Comments: *Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.
*Pharmacy may substitute a biosimilar based on insurance coverage.

Infusion Center Staff Please fax infusion records or discharge summary to:	Fax Number_____	
Provider Signature		Date
Provider Printed Name		